Performance

Report

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| Name of service: | Taralga Retirement Village Hostel |
| Service address: | 93 High Street JANDOWAE QLD 4410 |
| Commission ID: | 5110 |
| Approved provider: | Taralga Retirement Village Incorporated |
| Activity type: | Site Audit |
| Activity date: | 27 June 2023 to 29 June 2023 |
| Performance report date: | 8 August 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Taralga Retirement Village Hostel (**the service**) has been prepared by T Wurf, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s responses to the assessment team’s report received on 17 July 2023 and 1 August 2023
* the Performance Report dated 3 March 2022 for the site audit undertaken from 18 to 20 January 2022, which found 13 requirements of the Quality Standards non-compliant
* the provider’s response to a request for information made under Section 67 of the Aged Care Quality and Safety Commission Rules (2018), seeking the submission of further information/documentation relevant to requirements 2(3)(e), 3(3)(a) and 3(3)(b), received on 3 August 2023
* the monitoring assessment contact record dated 7 August 2023 based on the provider’s response to the request for information
* other information and intelligence held by the Commission, including the service’s compliance history.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Other relevant matters:

A site audit was undertaken at the service from 18 to 20 January 2022. The Performance Report dated 3 March 2022, for the site audit, found 13 requirements of the Quality Standards non-compliant.

A subsequent reaccreditation site audit was undertaken at the service from 27 to 29 June 2023. During this site audit, the performance of the service in those 13 non-compliant requirements was reassessed. This performance report is for the site audit undertaken in June 2023.

A request for information was made on 2 August 2023, under Section 67 of the Aged Care Quality and Safety Commission Rules (2018), seeking the submission of further information and documentation in relation to how the service ensures compliance with requirements 2(3)(e), 3(3)(a) and 3(3)(b). The provider’s response was received on 3 August 2023. A Monitoring Assessment Contact Record was completed based on the provider’s response. This performance report considers the Monitoring Assessment Contact Record findings under requirements 2(3)(e), 3(3)(a) and 3(3)(b).

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and their representatives said that staff treat consumers with dignity and respect and respect their cultural and individual preferences. They said the care provided makes consumers feel respected, valued and safe. Staff understood consumers’ backgrounds and preferences and described how this influences how they deliver care and engage in conversation with consumers.

The Assessment Team review a sample of consumers’ care documentation and found it was individualised and included information about consumers’ background and life stories.

Consumers and representatives said they were satisfied with the information they receive from the service and that they can make choices about their care and services.

Consumers felt supported to take risks, such as smoking or attending activities in the local community. Staff described how they support consumers to take risks and to minimise the risk of harm. Care documentation included risk assessments and forms relevant to identified risk activities.

Consumers were confident their personal information was kept private. Staff described strategies to maintain consumer privacy and confidentiality, such as not discussing consumer information in public spaces.

The service has policies to manage privacy, confidentiality, and information.

The Assessment Team observed:

* Staff interacting with consumers in a kind and caring manner, and engaging in conversations about living in a country area (consistent with consumers’ backgrounds).
* Staff using a range of communication strategies to engage with consumers in individual and group settings.
* Information about meal options and activity schedules were displayed throughout the service.
* Staff knocking on consumers’ doors prior to entering.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Performance Report dated 3 March 2022 found the service non-compliant with requirements 2(3)(a) and 2(3)(e), based on:

* 2(3)(a) - The service’s assessment and planning processes did not consistently consider risks to the consumer or were completed for new consumers to the service.
* 2(3)(e) – Consumers’ care and services were not reviewed regularly. Care plans were not routinely updated to reflect changes to consumers’ care needs following deterioration and/or review by other health professionals.

The Site Audit Report and approved provider’s responses identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements are listed below under relevant requirements, along with other relevant findings made by the Assessment Team in relation to those and other requirements under Standard 2.

*Requirement 2(3)(a)*

Improvements included:

* Updated assessment and care planning policies and procedures.
* Implemented a new a risk assessment tool used for consumers who take choose to take risks.
* Call bell alarms worn around consumers’ necks have a ‘quick release’ lanyard, which releases when any tension is applied.

Consumers and their representatives were satisfied with and involved in the service’s assessment and planning processes.

The service has policies and procedures to guide staff in assessment and care planning processes, which were understood by registered staff.

The Assessment Team reviewed a sample of consumers’ files and found that assessment and care planning considered risks to consumers. Risks to individual consumers’ health and well-being were identified, documented and manage. Risks included wounds, community access, falls, diabetes and complex nursing care.

*Requirement 2(3)(e)*

Improvements included:

* Implemented a 3 monthly care plan review schedule and ‘resident of the day’ process where registered and other staff review consumers’ progress notes and care documentation.
* Reminded registered staff that outcomes of reviews and recommendations are to be included in care plans.

Care documentation reviewed by the Assessment Team evidenced regular review of care and services, including the 3 monthly review and ‘resident of the day’ review processes.

However, the Assessment Team identified care planning documentation for five named consumers did not record outcomes or recommended strategies following review by other health professionals. These examples related to review by Dementia Services Australia of a consumer with changing behaviours and review by a dietitian of consumers experiencing unplanned weight loss. The Assessment Team found, however, that staff were aware of the recommended strategies and feedback from those consumers or representatives was positive.

I have considered the approved provider’s responses and am satisfied the service has taken action following the site audit to improve its systems and processes and update care documentation for named consumers. Evidence of actions included:

* Updated care plans for named consumers to include outcome and strategies following review by other health professionals.
* Updated the clinical manager’s daily clinical monitoring work instruction, which allocates dedicated time each shift to monitor care plans and ensure outcomes of reviews and/or recommendations from other health professionals are reflected in a consumer’s care plan.
* In August 2023:
  + staff training on the service’s electronic care management system, and
  + the clinical manager delivered one-on-one training to registered staff on updating consumers’ care plans following allied health reviews.
* Updated the assessment and planning process to require care plans to be updated following an allied health review.

*Other requirements*

The Site Audit Report included positive findings against each of the other requirements in Standard 2 summarised below.

Staff said they have access to care planning documents. The Assessment Team observed care planning documentation and relevant information available to staff delivering care.

Care documentation reviewed by the Assessment Team evidenced assessment and care planning that identified consumers’ needs, goals, and preferences, including advance care planning. End-of-life care planning is discussed with consumers and representatives on entry to the service and if a consumer’s condition deteriorates.

Care documentation also reflected case conferences with consumers and representatives, the involvement of other health professionals, and regular review of care and services.

Based on the findings contained in the Site Audit Report, the approved provider’s responses, and the improvements made by the service before and after the site audit:

* I am satisfied the deficiencies with the service’s assessment and planning have been remediated.
* It is my decision that each requirement and the overall Quality Standard are compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Performance Report dated 3 March 2022 found the service non-compliant with requirements 3(3)(a), 3(3)(b) and 3(3)(g), based on:

* 3(3)(a) - Clinical care delivery was not safe and effective in relation to the management of restrictive practices, continence and oxygen. The service’s management of pain and wounds did not reflect best practice.
* 3(3)(b) – Consumers with high-impact or high-prevalence risks related to their care were not effectively managed, particularly in relation to management of nutrition (weight loss) and falls.
* 3(3)(g) – The service’s processes to minimise infection-related risks were ineffective.

The Site Audit Report and approved provider’s responses identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements are listed below under relevant requirements, along with other relevant findings made by the Assessment Team in relation to those and other requirements under Standard 3.

*Requirement 3(3)(a)*

Improvement actions:

* Reviewed and updated the psychotropic register.
* Staff education on restrictive practice.
* Updated policies and procedures, including in relation to the management of restrictive practice, wounds, pain, and oxygen.
* Updated shift handover work instruction to include identification of clinical risks.
* Implemented a specialised nursing care list, which, for example, identifies consumers receiving oxygen.
* Implemented monthly visits to the service by a dietitian.

The Assessment Team reviewed a sample of consumers’ care planning documentation and found identification, assessment, monitoring and review of consumers’ clinical care needs including wounds, skin integrity and pain. Medical officers, registered staff and care staff monitor consumers’ wounds and skin integrity. Wound care documentation included photographs, regular charting, and improvement of wounds. Staff described monitoring of consumers’ pain and said pain charting is completed where required. Care documentation reflected monitoring of pain strategies for effectiveness.

In relation to restrictive practices, I have considered findings in the Site Audit Report and evidence in the approved provider’s responses. Evidence relating to whether psychotropic medications for some named consumers were used as a chemical restraint was conflicting and inconclusive. Whilst I am unable to draw a conclusion about this, I am satisfied that the service has relevant policies and procedures in place that reflect legislative requirements, the use of psychotropic medication is monitored and reviewed by medical officers and the clinical manager, and staff understand the types of restrictive practices and have received training on the topic.

*Requirement 3(3)(b)*

Improvement actions:

* Updated policies and procedures, including in relation to the management of restrictive practice, wounds, pain, oxygen, weight loss and falls.
* Updated shift handover work instruction to include identification of clinical risks.
* Implemented monthly visits to the service by a dietitian.

Care documentation reflected management of high impact, high prevalence risks to consumers, such as falls, behaviours and weight loss. Staff described strategies in place to manage risks for those consumers sampled by the Assessment Team. Falls are monitored and reviewed, and a physiotherapist attends the service weekly to review consumers’ mobility, equipment and falls. Consumers who have experienced weight loss are monitored and reviewed by a dietician and recommended dietary strategies are implemented. Clinical data is collected.

I have considered the Site Audit Report finding and approved provider’s response in relation to outcomes and recommended strategies from reviews by other health professionals not being documented in consumer care plans under requirement 2(3)(e).

*Requirement 3(3)(g)*

Improvement actions:

* Trained and appointed an infection and prevention control (IPC) lead and updated policies to reflect the requirement for the service to have an IPC lead.
* Established a process to monitor, review and report infections.
* Improved entry screening processes and mask-wearing etiquette.

The service has policies, procedures and an outbreak management plan (OMP) to guide staff in relation to antimicrobial stewardship, infection control and potential infectious outbreak. The service has a COVID-19 vaccination program and an appointed infection and prevention (IPC) lead. Staff described practices to prevent and control infections including hand hygiene, use of personal protective equipment (PPE) as required and encouraging consumers’ fluid intake.

*Other requirements*

Consumers and their representatives felt the care and services consumers receive was safe and right for them. They considered that consumers’ needs and preferences were effectively communicated between staff. Consumers and representatives provided positive feedback about the service’s management of clinical care, wounds and pain.

Staff said they have access to the information they need about consumers, including in the service’s electronic care management system and shift handover.

Care documentation for a consumer during end-of-life demonstrated pain was managed and monitored, regular communication with representatives, and review by the clinical manager and medical officer. Palliative care services and medical officers are accessed when required. Staff understood how to provide care and support to consumers nearing the end of life.

Care documentation demonstrated staff respond to changes in a consumer’s condition. Care staff described how they report changes or deterioration to registered staff or the clinical manager. Referrals to medical officers, or the local hospital are made as required.

The service makes referrals to other organisations and providers of care, such as allied health professionals, medical officers, and specialist dementia services. A dietitian, physiotherapist and medical officers attend the service regularly and specialist dementia services and geriatricians as required.

Based on the findings in the Site Audit Report, the approved provider’s responses and improvements made by the service:

* I am satisfied the service has remediated the deficiencies in relation to requirements 3(3)(a), 3(3)(b) and 3(3)(g).
* It is my decision that each requirement and the overall Quality Standard are compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers said they are supported to participate in meaningful activities within and external to the service, including gardening, swimming, going to the local shops, going on holiday, meeting with friends, playing cards with volunteers, and attending music concerts. Staff could describe the activities consumers participated in and relationships of importance to individual consumers.

The service has a monthly activity calendar with activities including exercise groups, cooking, and gardening. The Assessment Team observed consumers engaged in various activities during the site audit, including card games, exercise programs and craft activities, and staff providing one-on-one support to consumers.

Consumers and representatives were satisfied with the emotional, spiritual and psychological support provided to consumers. Consumers said they were comfortable speaking with staff who take the time to get to know them. Volunteers assist relevant consumers to attend church services.

Care planning documentation identified consumers’ individual lifestyle needs and preferences.

Consumers and representatives were satisfied that information is effectively communicated between staff. Information about consumers’ needs and services is documented and available to staff and others involved in their care, such as volunteers and National Disability Insurance Scheme staff. Information is shared via the electronic care management system and during staff handover.

The service makes referrals to individuals and other services to support consumers, including volunteers and entertainers.

Consumers and representatives were satisfied with the meals provided by the service. Consumers are offered a choice of meals and alternative options are available to them. Consumers’ dietary requirements and preferences are documented and known by staff. Menus are reviewed by a dietitian.

Consumers said the equipment is safe and they know how to report any concerns or issues. The service has processes for purchasing, servicing and replacing equipment. Equipment used to support consumers’ lifestyle activities was observed by the Assessment Team to be clean and well-maintained.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers were satisfied with the service environment and reported:

* the service is welcoming and easy for them to find their way around
* they feel safe and comfortable at the service
* positive feedback about the cleaning and maintenance, including their rooms
* they enjoy looking at the gardens
* there are a variety of places to sit with their visitors, and
* cleaners and maintenance staff do a good job keeping it the service clean and well-maintained.

The service has processes and schedules to clean consumers’ rooms and common areas, which were understood by the cleaning staff.

The service has systems to ensure furniture, fittings, and equipment are safe, clean, and well-maintained. Consumers said staff were safe and competent in the use of the equipment used to provide care and services.

Maintenance staff have preventative and reactive maintenance schedules and maintenance is attended to in a timely manner. Specialist maintenance staff are contracted to clean and maintain critical equipment and conduct tasks such as fire safety equipment testing and pest management. Hazards and incidents are investigated and escalated to managers and specialist contractors when required.

The Assessment Team observed:

* The service environment was welcoming, clean, well-maintained and easy to navigate with wide hallways and clear signage.
* Outdoor areas were well presented, shaded, and offered alternatives for consumers to interact with one another and loved ones.
* Consumers moving freely in and around the service, including those consumers using motility aids or receiving assistance from staff.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Performance Report dated 3 March 2022 found the service non-compliant with requirements 6(3)(c) and 6(3)(d) based on:

* Action was not consistently taken in response to complaints and the service did not have an open disclosure process.
* The service did not have a system whereby feedback and complaints were monitored, reviewed and trended, and used to inform quality improvement actions.

The Site Audit Report identified evidence that the service has taken actions, remediated deficiencies and improve its performance in these requirements. Improvements included:

* Implemented a monthly complaints and feedback meeting where management discuss feedback and complaints, continuous improvement and the reporting of these to Board meetings.
* Updated the complaints policy in May 2022 with information about complaints management, open disclosure, and links to quality systems and the service’s plan for continuous improvement.
* Updated complaints data to record outcomes of complaints and feedback.

The Site Audit Report also included relevant findings in relation to those and other requirements under Standard 6 as follows.

Consumers and representatives said they were:

* aware of and comfortable using the service’s mechanisms to providing feedback and complaints, such as consumer meetings, raising feedback/complaints directly with staff or management, and completing the service’s ‘Feedback Form’
* aware of external mechanisms for raising and resolving complaints, and access to advocacy and language services
* satisfied with the actions taken in response to their complaints, including that they received an apology and explanation, and
* aware of improvements made at the service in response to their feedback, such as relocation of the smoking area.

The service has a complaints management system that documents feedback and complaints, actions taken in response and the use of open disclosure. The service has a complaint handling policy that includes the use of open disclosure.

Management and staff had a consistent understanding of the service’s complaints management processes. Open disclosure was understood and used by staff in response to complaints and when things go wrong.

Information about the service’s feedback and complaints is provided in the service’s newsletters and entry pack, and displayed on posters around the service. Complaints forms were available at the entrance of the service.

The service reviews and uses feedback and complaints to improve the quality of care and services. The service’s complaints register and plan for continuous improvement document improvements made as a result of feedback and complaints.

Based on the findings in the Site Audit Report:

* I am satisfied the service has remediated the deficiencies in relation to requirements 6(3)(c) and 6(3)(d), and the service has a system to resolve complaints and use feedback and complaints to improve the quality of care and services.
* It is my decision that each requirement and the overall Quality Standard are compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Performance Report dated 3 March 2022 found the service non-compliant with requirements 7(3)(d) and 7(3)(e). Deficiencies included:

* The service does not have processes to identify, monitor or record staff training requirements and staff have not received regular training relevant to their role, including mandatory training.
* The service did not have effective systems and processes in place to assess, monitor and review staff performance

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in these requirements, including implementing a new:

* Annual education plan which includes mandatory training.
* Process for monitoring staff training; a role-specific training register, with each manager of the designated team being responsible for its completion. Monitoring and oversight are completed by the clinical manager.
* Performance report for staff.
* Performance register which is monitored and reviewed monthly by the clinical manager. The new process includes electronic messages sent to staff and their respective managers for follow-up for an upcoming review.

The Site Audit Report also included relevant findings in relation to those and other requirements under Standard 7 as follows.

Consumers and their representatives provided positive feedback about staff and said there are enough staff at the service. They said staff:

* are available when needed and attend promptly to requests for assistance
* engage with them in a respectful, kind, and caring manner,
* are gentle when providing care, and
* are skilled, knowledgeable, well-trained, and competent in providing care and services that meet their needs.

Staff considered there was enough staff to deliver care and services in accordance with consumers’ needs and preferences, and said they generally have enough time to complete their allocated tasks. Staff said they regularly complete online and in-person training relevant to their role, including mandatory training.

Management said the service regularly reviews staff rosters to ensure staff allocations are meeting the changing needs of the consumer cohort. Staff are replaced where required. The service implemented a new call bell system in June 2023 that provides call bell data, which is reviewed by the service.

The service determines staff competency through processes such as skills assessments, performance appraisals, consumer/representative feedback and complaints, consumer surveys, and review of clinical records.

The service has processes to recruit, train and support the workforce. Position descriptions are available for various roles. The service has processes for monitoring staff criminal record checks, professional registrations and vaccinations. New staff receive orientation, are buddied with more experienced staff. Staff have completed mandatory training.

The performance of the workforce is monitored and reviewed. Management monitors staff interactions with consumers through observations, analysis of clinical data and consumer/representative feedback. Staff they said have been involved in probation and performance appraisal processes at the service. The service has a system to compete performance reviews.

The Assessment Team observed:

* kind, respectful and patient interactions between staff and consumers, and
* staff responding promptly to consumers’ requests for assistance.

Based on the findings in the Site Audit Report:

* I am satisfied the service has remediated deficiencies in relation to human resources.
* It is my decision that each requirement and the overall Quality Standard are compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The Performance Report dated 3 March 2022 found the service non-compliant with requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). The deficiencies related to:

* The organisation’s governing body was not promoting a culture of safe, inclusive, quality care and services and were not accountable for their delivery.
* Governance systems for information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.
* Risk management systems, policies and practices.
* Clinical governance framework and policies.

The Site Audit Report identified evidence that the service has taken actions to remediate the deficiencies and is meeting the above requirements. Improvements included:

* Created a new management report to deliver information to the Board including about clinical care and quality indicators.
* Increased Board members’ involvement within the service. For example, Board members work in the kitchen and in the gardens and attend staff meetings where possible.
* Improved organisational wide governance systems:
  + Reviewed and updated the service’s policies and procedures, including to be consistent with legislative requirements, including for
    - records management
    - restrictive practices, and
    - incident management.
  + Implemented education audits to test staff understanding following education.
  + New processes to record and action feedback and complaints, and include feedback and complaints in the service’s continuous improvement system.
* Reviewed and updated the service’s risk management framework, and policies, procedures and forms related to risk.
* Implemented a workflow chart for staff to utilise when assessing risk.
* Reviewed the clinical governance framework and updated policies and procedures relating to antimicrobial stewardship, restrictive practices, open disclosure, risk management, and workforce governance.
* Educated staff on various topics including restrictive practices, open disclosure, complaints, and the serious incident response scheme.

The Site Audit Report also included relevant findings in relation to those and other requirements under Standard 8 as follows.

Consumers and representatives were confident the service is well run and they can provide feedback and suggestions about care and services directly to staff and management. Management described how consumers are engaged through consumer meetings, feedback forms and providing feedback directly to management.

The organisation has implemented systems and processes to monitor the performance of the service and to ensure the Board is accountable for the delivery of care and services. The organisation’s governance policies identify a leadership and accountability structure.

The service has effective governance systems and processes relating to information management, continuous improvement, financial governance, workforce management, regulatory compliance and feedback and complaints.

The service has a documented risk management and clinical governance frameworks, policies and procedures that guide how the service manages risk, incidents, antimicrobial stewardship, restrictive practices, and open disclosure. Staff receive training on various topics that relate to risk and clinical governance and demonstrated an understanding of these areas relevant to their role.

Based on the findings in the Site Audit Report:

* I am satisfied the service has remediated deficiencies in relation to organisational governance.
* It is my decision that each requirement and the overall Quality Standard are compliant.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)