Performance

Report

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| Name of service: | The Sydney-Lynne Quayle & Fitzroy Lodge Hostels |
| Service address: | 21 Barclay Street HEYWOOD VIC 3304 |
| Commission ID: | 3354 |
| Approved provider: | Heywood Rural Health |
| Activity type: | Site Audit |
| Activity date: | 13 September 2022 to 16 September 2022 |
| Performance report date: | 18 November 2022 |

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 The Sydney-Lynne Quayle & Fitzroy Lodge Hostels (**the service**) has been prepared by D. Fekonja, 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 response to the assessment team’s report received on 02 November 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-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

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 2**

* Ensure care planning documents always provide evidence of assessment and planning that considers current risks to the health and well-being of the consumers.
* Ensure care planning documents inform the strategies to mitigate any identified risks.
* Ensure incidents are correctly recorded in both the incident management system and consumer files.
* Ensure behaviour support plans are in place for consumers subject to restrictive practices or with behaviours of concern.

**Standard 3**

* Ensure consumers subject to chemical restraint are identified and consent obtained and they are monitored and regularly reviewed and minimisation strategies employed.
* Ensure that falls protocols and seizure management protocols are followed and that staff are provided education in these processes.

**Standard 4**

* Ensure the menu is updated as per the continuous improvement plan, is nutritionally balanced and a variety of options are available for consumers to select.
* Ensure the food is delivered at a suitable temperature.
* Ensure the menu is a seasonally rotating menu that is approved by a dietitian and trialled by consumers prior to introduction.

# 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

This Quality Standard is Compliant as six of the six requirements have been assessed as Compliant.

Consumers and representatives confirmed staff treat consumers with respect and dignity and that their identities are valued as individuals. The Assessment Team observed staff treating consumers gently and with respect and demonstrated an understanding of consumers’ individual choices and preferences. Care plans reviewed document the consumers’ individual preferences, important relationships, and traditions they wish to honour.

Consumers confirmed they are supported to exercise choice and independence about their care and the connections they make. The service has adopted the philosophy of ‘person-centred care’ meaning care provision is based on a collaborative and respectful partnership between the consumers and staff. Two consumers informed the Assessment Team of the enjoyment they gained from attending the ‘men’s shed’ and having the opportunity to chat with other attendees and listen to guest speakers.

Care staff told the Assessment Team how they assist consumers to independently access the town using electronic mobility aids or partaking in outings with families and friends. Care plans reviewed by the Assessment Team contained signed ‘dignity of risk’ forms confirming the consumers, and/or their representative was aware of the risk associated with the activity the consumer wished to continue participating in.

Consumers and representatives said they are satisfied information provided by the service are current, easy to understand, and overall, enables consumers to exercise choice. The service has implemented a mobile phone application ‘family app’ as a communication tool between families and consumers. Photographs, newsletters, activity planners, and other important and relevant information is placed on the ‘family app’.

Consumers and representatives said the service respects consumers’ privacy and confirmed personal information remains confidential. Staff were observed knocking on consumers’ doors before gaining entry to rooms. Electronic care plans are password protected with access provided on an ‘as needs’ basis. The service has policies and procedures in relation to keeping personal information confidential.

# 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. | Non-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. | Non-compliant |

Findings

I have assessed the Quality Standard as Non-compliant as I am satisfied requirements 2(3)(a) and 2(3)(e) are Non-compliant.

Although consumers on the whole were satisfied with the assessment and care planning process the Assessment Team found that there were deficits in the care planning process. Care planning documents did not always provide evidence of assessment and planning that considers current risks to the health and well-being of the consumers. Where risks were identified, including restrictive practice, falls, seizures, and responsive behaviour, care planning documents did not always inform the strategies to mitigate the identified risks.

The service did not demonstrate care and services were reviewed for effectiveness when circumstances change or when incidents impact the needs or goals of consumers. Documentation did not always evidence recommended strategies following reviews are transferred to the consumers’ care plans to inform the delivery of safe and effective care.

For one consumer who was prescribed ‘as needed’ anti-psychotic medication to manage and modify their behaviours, this was administered 18 times between 23 June and 13 September 2022. There was no evidence that there was monitoring of side effects nor a behaviour support plan in place. Intervention strategies trialled were ineffective. Although many of the behaviours occurred overnight there was no evidence of a sleep assessment having been completed. Progress notes did not reflect a discussion with the consumer’s representative in relation to the regular and PRN psychotropic medication usage and informed consent. Staff told the Assessment Team they were not of the opinion the consumer was subject to chemical restraint and acknowledged the deficits in the documentation of the interventions trialled and their effectiveness. Management also stated that the medical practitioner, and/or the nurse practitioner obtain consent forms for all psychotropic medications. They have now completed ongoing medication reviews for this consumer, and they are now under the service’s regular medical practitioner as this consumer is now a permanent resident.

A second consumer who has numerous falls but is resistant to care provided following the falls has not had observations or monitoring reflected in their file following the fall, although staff stated they did occur. There is no documentation to advise that observations have been conducted but refused by the consumer following incidents such as falls. The falls were also not documented as incidents.

On two occasions a third consumer experienced seizures, their progress notes reflect vital observations were completed and within normal limits, however, these are not documented in the consumer’s file. Documentation did not evidence further observation and monitoring were completed after the seizure episode. On 3 occasions the documentation did not reflect the consumer was reviewed by a medical practitioner following their seizure episodes. This consumer also suffered a fall and during a physiotherapy assessment complained of ankle pain and progress notes document staff believed this complaint to be behavioural. This information is not reflected in their fall’s risk assessment and behaviour care plan. Management confirmed to the Assessment Team there are no risk assessments and seizure management plans in place for this consumer. They also acknowledged the gaps in the documentation and the post-fall management. This consumer‘s last pain management assessment plan was completed on 13 May 2022 even though they have complained of pain due to the recent falls.

Management advised that a quality improvement activity had commenced in March 2022 to address the gaps in assessment and care planning documentation. This activity was to be completed by 30 September 2022, however, the Assessment Team found there had not been adequate progress and improvement in relation to the identified gaps in the documentation.

The approved provider in their response acknowledged there were deficits in some areas of assessment and planning and the recording of incidents. They also stated one of the consumers named was actually in the co-located service but this is in conflict with the list the service provided to the Assessment Team during the site audit. They provided evidence of the improvements made in relation to a number of issues outlined by the Assessment Team, these include:

* Engaging a Nurse Consultant in Jan 2022 to review the current standard of clinical documentation, particularly around assessment, care planning and evaluation.
* Reinstated a Clinical Documentation Committee to monitor the standard of all aspects of clinical documentation.
* Will conduct a Clinical Care Safety Huddle for key assessment and care planning for residents in line with identified risks and associated clinical deterioration, which in turn informs safe and effective care.
* Will commence a Multidisciplinary Team Meeting to provide a regular communication forum for Nursing, Healthcare Workers, Allied Health and Lifestyle staff to discuss the physical, social, and emotional needs of residents.
* Creating post-incident checklists.

The files of the named consumers are said to have been updated with the required information. The approved provider also refuted claims that incidents are not investigated and analysed for trends and stated they are discussed at regular incident huddles to ensure care requirements for residents post-incident are monitored and appropriate follow-up carried out.

Whilst I am encouraged by the improvements the approved provider has put in place, the processes and improvements are not yet fully embedded into practice and I am satisfied that requirements 2(3)(a) and 2(3)(e) are non-compliant.

I am satisfied that the remaining three requirements of Standard 2, Ongoing assessment and planning with consumers are compliant.

Consumers and representatives said care and services are planned around what is important to consumers. Staff demonstrated knowledge of the consumers’ current needs and preferences including their end-of-life wishes.

Most consumers and representatives described being able to participate and develop partnerships with whomever they wish to involve in the assessment, planning and review of their care.

Consumers and representatives said they are generally satisfied with the level of communication they receive about the outcome of consumers’ assessment and planning. Care documentation reflects the communication of relevant information with consumers and representatives

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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

I have assessed the Quality Standard as non-compliant as I am satisfied requirements 3(3)(a) and 3(3)(b) are non-compliant.

The Assessment team found that the service did not identify, effectively monitor, or regularly review the use of chemical restraint or other prescribed psychotropic medications. The psychotropic self-assessment tool did not identify any consumers subject to chemical restraint. However, the Assessment Team reviewed the service’s psychotropic self-assessment tool and identified 3 consumers who are prescribed regular, and ‘as required’ (PRN) psychotropic medications indicated for behaviour disturbance, anxiety, and agitation.

The organisation’s restrictive policy indicates ‘signed consent forms are obtained for all psychotropic medications and it cannot be commenced unless the medical practitioner documents the indication on the progress notes’.

The service management at the time stated that consent is only obtained for medications prescribed as chemical restraint and the medical practitioner, or the nurse practitioner gains verbal consent from the consumer and/or representatives for all psychotropic medications prescribed and it is then documented in the psychotropic self-assessment tool. The service does not believe there are any consumers subject to chemical restraint and they are prescribed anti-psychotics and psychotropics based on a medical diagnosis.

For one consumer it is noted in their Dementia Services Australia plan that they are to be given ‘Clonazepam’ prior to hygiene being provided. In relation to this the approved provider states this is in order to manage her behaviours to promote her wellbeing and support staff in being able to meet her care needs (page 34 of their response).

For one consumer wound charting evidenced that wound management is completed in line with the wound regime recommended by the nurse practitioner. However, gaps in documentation were identified when the wound chart was incompletely updated by the nurse on 2 days in August 2022. On both occasions, the wound charting did not reflect the interventions provided and the current wound status.

The Assessment Team also found the service did not demonstrate effective management of falls and seizures for high-risk consumers. Documentation did not always reflect effective management of falls and seizures in line with best practices. Incidents are not always documented in line with the organisation’s policy and procedure.

One consumer did not have consistent neurological observations recorded as being performed following falls and another was not reviewed by a medical practitioner following seizures on three occasions.

The approved provider refuted the claims made by the Assessment Team and stated that a Nurse Unit Manager checks the Psychotropic Medications Register each week on a Monday. This is signed to show it has been completed and the electronic medication system triggers an alert for the medical practitioner to review the medication every 12 weeks. They also stated that the last Psychotropic Medication Audit in November 2021 did not identify any consumers subject to chemical restraint and they did not currently have any subject to chemical restraint.

The approved provider’s Psychotropic Medication Management document states:-

‘The use of psychotropic medications is not considered a form of chemical restraint unless the purpose of these medications is to restrict the resident’s movement or ability to make decisions’.

I am satisfied that the service is not identifying that consumers are subject to chemical restraint when psychotropic medication is given to prevent resistive behaviours. Although the consumer may have a diagnosis of dementia, psychotropic medication is not being provided to treat the condition but is being used to influence the consumer’s behaviours, as per Section 15E of the Quality of Care Principles. This is identified as being the case for the consumer who is to be given ‘Clonazepam’ prior to personal care being provided.

The approved provider acknowledged that there are improvements to be made in relation to the management of falls and consumers suffering seizures. They have created a seizure policy and have reviewed its Falls Prevention and Management policy and procedure. A high-risk handover tool will be reinstated and education on incidents will be provided.

I am satisfied that wound care is being provided adequately and that a new wound management policy and procedure has been developed with education planned for staff.

I am satisfied that requirement 3(3)(a) and 3(3)(b) are non-compliant.

The remaining five requirements of Standard 3 Personal care and clinical care are compliant.

Care planning documents demonstrate the service meets the needs of palliating consumers to ensure comfort care with dignity and that palliative care planning is individualised and tailored to the consumer’s wishes.

Consumers and representatives expressed satisfaction with how the service responds to a change or deterioration in condition, health or ability when recognised.

Consumers and representatives said they are happy with the level of communication they receive from the service. Although, care planning documents do not always reflect information about the consumers’ condition, progress notes, and handover sheets reflect current information about consumers' condition, needs, and preferences. Documentation reflects timely and appropriate referrals to individuals, other organisations and providers of other care and services.

Consumers, representatives, and staff said they are satisfied with how the service managed the recent COVID-19 outbreak.

The service’s infection and antimicrobial stewardship were managed effectively. The service uses a collaborative approach with the medical practitioner and the nurse practitioner to minimise the use of antibiotics, by ensuring results from appropriate pathology testing guide antibiotic prescribing.

# 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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I have assessed the Quality Standard as Non-compliant as I am satisfied requirement 4(3)(f) is Non-compliant.

The Assessment Team found the service is not supplying consumers with meals of a suitable quality to adequately support their nutrition and dietary needs. A dietitian’s review of the evening and light meal options outlined there was an overall lack of vegetables or fibre and relied on frozen ‘junk food’. There were also issues identified with meal temperature and food being undercooked. At the time of the site audit, management confirmed a new menu reviewed by a dietitian was to be trialled however there was no evidence of this in the continuous improvement plan viewed by the Assessment Team or details of the commencement date.

The approved provider’s response provided information clarifying a number of reasons for the delays in trialling and commencing the new seasonal menu including kitchen staff being unavailable. The approved provider has also provided information on the capital equipment needed to upgrade the cooking facilities and the staffing requirements for the proposed new method of food service. This new seasonal menu which has been reviewed by a dietitian will not come into effect until March 2023. There was also evidence from a resident satisfaction survey said to be conducted in October 2022 that showed general satisfaction with the food provided however there were still concerns in relation to food temperature. Eight per cent of consumers were still unhappy with the food quality and variety.

Although I find the approved provider has taken significant steps to improve the food quality and variety at the service, this has yet to be implemented and the current menu is still in place with all of the issues outlined in the Assessment Team report including dissatisfaction with the temperature of meals. The current menu was also reviewed by the dietitian at the time and they had concerns surrounding the evening meal offerings in relation to dietary fibre and vegetable content. I note that on one day of the menu viewed by the Assessment Team that there are only 2 vegetables documented for the whole day. There was also soup served during the assessment which had not been approved by the dietitian and consumers stated was undercooked.

I find the service non-compliant with this requirement as although there are improvements underway these are not due to be completed and embedded until March 2023.

I am satisfied the remaining six requirements of Standard 4 Services and supports for daily living are compliant.

Care plans evidence consumers’ needs, goals, and preferences are captured following entry into the service to ensure their independence, health, and well-being are optimised. Information captured enables staff to provide appropriate leisure and lifestyle activities and encourage socialisation. There is a mobile library that loans books to consumers and visiting entertainers and volunteers that support the leisure and lifestyle staff to provide activities of interest to most consumers.

Consumers and representatives agreed the service provides support for daily living that promotes the consumer’s emotional and spiritual health. Information captured in care plans advises staff on relationships important to each consumer, and the spiritual fulfilment and emotional support required. Consumers and representatives said consumers are assisted to participate in their community within and outside of the service and to have social and personal relationships.

Care plans evidenced information is captured to inform staff, medical practitioners, and allied health professionals about each consumer’s clinical condition, needs, goals, and preferences. Consumer representatives confirmed they are informed whenever changes occur to consumers.

The service refers consumers to individuals, other organisations, and providers of care when required. Care plans sampled evidence referrals made are attended to in a timely manner for consumers requiring assessments by speech pathologists, dietitians, and podiatrists.

Consumers and representatives confirmed the equipment provided is safe, suitable, and clean and management is responsive to furniture requests. Leisure and lifestyle staff described being supported to purchase equipment required for activities as needed.

# 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

This Quality Standard is Compliant as three of the three requirements have been assessed as Compliant.

The service provides accommodation for consumers requiring memory support and low-care and is co-located with a high-care service. Consumers and representatives said the service environment is welcoming and easy to understand. The memory support unit (MSU) provides consumers with a secure environment accessed through a keypad-locked door. A secured garden is accessible to consumers residing in the MSU. The MSU recently underwent a refurbishment and consumers were very happy with the improvements to the service. Consumers were happy with the new carpet and one consumer stated that the unit finally feels like home.

Consumers said they feel safe residing at the service and are satisfied with the cleanliness of the service. The Assessment Team observed the service to be well-maintained, clean, and comfortable with unrestricted access to the outdoors throughout the day. Consumers residing in the MSU can freely access a secured garden with raised garden beds and sensory plants. Scheduled maintenance is performed according to the annual schedule. Health and safety audits are conducted to ensure paths of travel remain free of hazards and obstacles.

The service monitors consumer satisfaction with the accommodation and living areas through annual experience surveys. One of the issues identified by a survey was consumers did not like the seating in the communal areas and these were replaced with bigger more comfortable chairs.

# 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

This Quality Standard is Compliant as four of the four requirements have been assessed as Compliant.

Consumers and representatives said, they feel encouraged and supported to provide feedback and make complaints. Clinical staff described helping consumers resolve minor concerns and requests or escalating more complex issues to senior management. Clinical staff and management personnel said they encourage feedback by conducting consumer experience surveys, holding resident and relative meetings, and showcasing improvements made arising from consumer feedback on a noticeboard.

Consumers and representatives said that they were aware of advocacy and language services. Staff could describe the advocacy and language services available to assist consumers. The Assessment Team sighted advocacy services brochures, language services brochures, and Commission brochures in key locations around the service. Brochures are available in languages other than English. The welcome pack provided to new consumers also contains information about how to access advocacy and language services.

Consumers who described providing verbal feedback to staff said they were satisfied appropriate action was taken in response to feedback and requests. Staff and management personnel described using open disclosure principles in relation to incidents and complaint handling. One consumer was very satisfied with the action taken with all the complaints they had lodged in the previous six months.

Consumers and representatives described being contacted after making complaints and how staff actions had led to improvements. The complaints log and continuous improvement documentation demonstrated how complaints and feedback are used to make improvements at the service such as a 'moving in' survey for new residents to ensure they can provide feedback after entering the service.

# 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

This Quality Standard is Compliant as five of the five requirements have been assessed as Compliant.

The Assessment Team found that the service was not met in requirement 7(3)(e) as it was not conducting staff performance appraisals in accordance with its policies and procedures, and some staff were unable to recall participating in the performance appraisal process. Documents showed that approximately half of all staff are overdue for participating in their next scheduled performance appraisal. This was confirmed during the site audit by management and the reasons given were in relation to staff and managerial changes.

Consumers and representatives feel there is enough staff to enable the provision of safe and quality care and services. The service demonstrated its capacity to plan the workforce to ensure vacant shifts are filled and roles are filled when vacancies become available. The Assessment Team observed staff responding to consumers and/or call bells in a timely manner throughout the site audit.

The Assessment Team observed staff interactions to be kind, caring and respectful during the site audit. Interactions demonstrated that staff had an intimate knowledge of consumers’ life stories and preferences. This was confirmed by consumers and representatives.

The Assessment Team found the workforce to be competent, with staff having the qualifications, knowledge, and skills to effectively perform their roles. Consumers and representatives described staff as having the knowledge and skills to meet their needs in a variety of areas of clinical care. Qualifications and registrations of clinical staff are monitored and kept up-to-date.

Consumers and representatives feel that staff are recruited, trained, and supported to provide care and services that meet their needs. Staff said they feel supported and trained to perform their roles effectively and they gave examples of training they had undertaken. The Assessment Team sighted the 2022 education calendar evidencing scheduled training sessions. The schedule identifies different training needs for different roles at the organisation.

The approved provider in their response outlined that performance appraisals were not able to be completed during COVID-19 outbreaks as staff were only permitted to work at a single service and thus were not always in attendance at this service. Another factor cited was the nurse unit manager being unable to conduct the appraisals due to numerous factors including having to cover staff absences due to COVID-19 outbreaks and staff illness.

The service has initiated a variety of measures to increase the number of appraisals conducted and at the time of their response, it is claimed 78% of staff have had appraisals conducted with an expected level of 85% to be achieved by 18 November 2022.

I am satisfied with the improvement made in relation to the measures taken to improve the number of appraisals conducted. The approved provider demonstrated a rapid response that was initiated to increase the number of performance appraisals since the site audit and has measures in place to ensure to continue the process.

I am satisfied the service is compliant with all requirements under Standard 7 Human Resources.

# 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

This Quality Standard is Compliant as five of the five requirements have been assessed as Compliant.

Consumers said they feel supported and engaged in the development, delivery and evaluation of care and services. Consumers confirmed being invited to attend meetings to discuss the communication bulletins and/or participate in the consumer advisory group.

Consumers and representatives described living in a safe and inclusive environment and being provided with quality care and services. The service has a variety of policies and processes to guide staff in providing quality care.

The service demonstrated effective governance systems in relation to information management, financials, workforce governance, regulatory compliance, and feedback/complaints. The service has a governance system to coordinate continuous improvement. While the Assessment Team found not all continuous improvement activities had been actioned in a timely manner, the service demonstrated progress on most continuous improvement activities.

The service has risk management systems to monitor and assess the high impact or high prevalence risks associated with the care of consumers. Risks are reported, escalated, and reviewed by management at the service level and in quality indicator meetings. Management explained how difficulties recruiting staff posed a risk to consumers across all areas of clinical care and the initiatives it has implemented to ensure enough staff are at the service.

The service provided a copy of its clinical governance framework. Management personnel described their clinical governance roles and responsibilities, including the running of clinical and quality meetings to monitor clinical indicators and the consumer experience. The service demonstrated how its clinical governance framework supports the use of open disclosure, the practice of antimicrobial stewardship, and the minimisation of restraint.

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