Performance

Report

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| Name of service: | The Whiddon Group - Kelso |
| Service address: | 15 Ilumba Way KELSO NSW 2795 |
| Commission ID: | 0269 |
| Approved provider: | The Frank Whiddon Masonic Homes of New South Wales |
| Activity type: | Site Audit |
| Activity date: | 1 November 2022 to 8 November 2022 |
| Performance report date: | 24 January 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 The Whiddon Group - Kelso (**the service**) has been prepared by James Howard, 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 conducted from 1 November 2022 to 8 November 2022; 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 Approved Provider’s response to the Assessment Team’s report, received on 6 December 2022.
* Other information and intelligence held by the Commission in relation to the service.

# 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 | **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.

* Requirement 2(3)(a) – The service must ensure effective assessment and planning, including the consideration of risks to the consumer’s health and well-being.
* Requirement 3(3)(a) - The service must ensure each consumer gets safe and effective care that is best practice, is tailored to their needs, and optimises their health and well-being.
* Requirement 3(3)(g) – The service must ensure the minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection.

# 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 confirmed they were treated with dignity and respect, and staff valued their identities, cultures and diversity. Care planning documentation identified consumers’ cultural needs and preferences.

Staff demonstrated familiarity with the cultural needs and preferences of consumers. The service had processes in place to understand and document the consumer’s life history, including their cultural needs and preferences.

Consumers were satisfied they were supported to exercise choice and independence, had the ability to make their own decisions and maintain personal relationships. Care planning documentation reflected consultation and involvement of individuals of importance to consumers.

Consumers described how they were supported to take risks to live the best lives they can. The service had a range of assessments to support consumers to make choices and take risks which included strategies to mitigate risks.

The Assessment Team observed information was provided to consumers in a manner that was clear and easy to understand. Consumers expressed they were kept well informed regarding their care and services.

Consumers and representatives reported their privacy was respected and staff knocked on their doors and awaited a response prior to entering. The service had a range of policies and processes to ensure consumer’s privacy was respected and personal information was kept 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. | Compliant |

Findings

*Requirement 2(3)(a):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate effective assessment and planning processes, including the consideration of risks to the consumer’s health and well-being.

The site audit report noted:

* A consumer indicated they managed their diabetes for multiple years; however, a review of their care planning documentation did not include a diagnosis of diabetes listed in any of their reviewed documents. Management were informed of this discrepancy and indicated they would follow up with their diagnosis and care plan, as they needed to clarify the consumer’s diagnosis.
* A consumer was observed on 2 November 2022 to possess prescription eye drops, which were stored in the fridge within their room. The consumer’s care planning documentation did not document the need for eye drops nor when the use of eye drops commenced or should be ceased. These eye drops were further noted to have been opened on 8 September 2022, with instructions to be discarded after twenty eight days of use. Management were advised of this issue and advised they were unaware of the consumer possessing the eye drops and the consumer did not have a self-medicating risk assessment in place. Management further indicated they would continue to review and investigate how the eye drops came to be stored in the fridge and if the consumer had been self-administering.
* A consumer’s care planning documentation provided conflicting information regarding the person responsible for making decisions regarding the consumer’s care needs. Management advised the consumer was previously under the guardianship of the Public Trustee; however, this order was no longer required and there now needed to be ongoing involvement with the consumer’s general practitioner and enduring power of attorney. There was no information documented to reflect the consumer’s general practitioner was involved in their assessment or care planning.

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* Concerning the consumer managing their diabetes – the service acknowledged the inconsistencies and advised a diabetes screening and management form was originally completed in July 2021, but was inadvertently archived. The consumer’s diagnosis list has since been updated to include diabetes, and a new diabetes screening management assessment has been created. In addition, the service has reviewed all consumers with a diagnosis of diabetes to ensure their care planning documentation contains accurate information.
* Concerning the consumer with prescribed eye drops – the service advised it conducted an internal audit and the service is confident there were no other medications stored inappropriately at the service. The service further advised of improvements being implemented to minimise the occurrence of similar issues in the future, which included:
  + Training and education to be provided to staff regarding the service’s medication policy and appropriate medication storage.
  + The cleaning schedule has been updated to check rooms for stored medication. These checks will also be completed by the registered nurse on a weekly basis.
* Concerning the consumer with conflicting care planning information regarding the individual responsible for decision making – the service has conducted a review of all consumers to ensure there is clear documentation regarding the person responsible for decision making. The importance of communicating with consumers, the person responsible and their families had further been addressed through a memo sent to staff, and staff training.

In reaching my conclusion, I considered the information presented by the Assessment Team and the Approved Provider. I acknowledge the actions taken by the Approved Provider to address the identified issues. Due to the conflicting findings of the care planning documentation review conducted by the Assessment Team, I consider that at the time of the site audit, the service did not demonstrate effective assessment and planning, including the consideration of risks to the consumer’s health and well-being. Therefore, I have decided the service is Non-compliant with Requirement 2(3)(a).

*Requirement 2(3)(d):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate that outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and services plan.

The site audit report noted:

* A consumer’s representative was not contacted, and their care planning documentation did not document information regarding their changed care needs following the consumer experiencing a series of falls, some of which resulted in being transferred to hospital.

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* The service acknowledged there was a delay in updating the consumer’s care plan and have since updated the consumer’s documented care and services.
* Prior to the site audit, the service had commenced a continuous improvement log to ensure care planning involved consumers, and they were updated with information outlining consumers preferences, choice was acknowledged and respected. The service have indicated consumer care plan reviews will occur in consultation with the consumer and representative every three months.

I considered the information provided by the Assessment Team and the Approved Provider. Whilst I acknowledge there were deficits in the service’s communication of outcomes and assessment and this constituted a departure from best practice, there was no identified adverse impact on consumers resulting from these deficits. Therefore, having considered all relevant information, I decided the service is Compliant with this requirement.

*The other Requirements:*

Care planning documentation identified and addressed the consumer’s current needs, goals and preferences, including advance care planning and end of life planning. Staff demonstrated an understanding of the needs and preferences of consumers and advised they could access the electronic care system if they required additional information.

Care planning documentation demonstrated consumers and representatives were consulted throughout assessment and care planning and, when required, staff sought input from health professionals. The Assessment Team observed the occurrence of a shift handover, and staff were communicating any consumer care need changes.

Consumers and representatives expressed positive feedback regarding the regularity of review of their care and services. Care planning documentation confirmed care plans were reviewed on a regular basis, when consumers’ circumstances changed, or incidents occurred.

# 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. | 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. | Non-compliant |

Findings

*Requirement 3(3)(a):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate each consumer received safe and effective clinical care that was best practice, tailored to their needs and optimised their health and well-being.

The site audit report noted:

* The authorisation documentation forms for a consumer’s chemical restraint management were not in line with best practice.
* A consumer indicated they experienced aching pain during the night and could only return to sleep once assistance was sought from staff and they provided the consumer with pain relief. The consumer further indicated they self-administered pain relief medication prior to their wound dressing being changed as staff can be rough when providing care.
* A consumer outlined they experienced prolonged periods of time with leg pain and indicated staff advised the consumer they were unable to assist with their pain needs as they did not have any chartered medication for them. Management were advised of the consumer’s feedback during the site audit and the service indicated they would review the consumer’s plain to their medical officer to discuss strategies and assist their pain needs.

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* Concerning the authorisation documentation forms – the service acknowledged there were discrepancies with the dates of signed authority for restrictive practice usage between the consumer’s representative and medical officer, however provided supporting documents which evidenced the service maintained overall compliance. Additionally, the Approved Provider indicated they will implement the following continuous improvement actions:
  + Education to staff and distribution of the service’s restrictive practice policy.
  + Ongoing monitoring and oversight by the service’s quality team.
* Concerning the consumer that self-administered pain relief medication – the service indicated the consumer was prescribed pain relief medication for self-administration; however, did not always adhere to this prescription, resulting in ineffective pain management. A toolbox talk was provided, to ensure staff were gentle when providing care and for pain to be effectively managed during the wound care process.
* The service acknowledged there were areas for improvement in relation to pain management, and advised it took the following actions:
  + Training and education provided to staff to re-enforce wound care and pain management.
  + The implementation of an assessment tool to assist in assessing consumers’ pain.
  + A review of consumer’s pain assessments, progress notes and pain flow chat to ensure compliance with the service’s pain management policy.
  + Increased clinical oversight of pain relief medication usage and consumers experiencing pain.

In reaching my conclusion, I considered the information presented by the Assessment Team and the Approved Provider. I acknowledge the actions taken by the Approved Provider to address the identified issues. However, due to the feedback provided to, and the observations made by, the Assessment Team I consider that at the time of the site audit, the service did not demonstrate effective pain management care for all consumers that was tailored to their needs and optimised their health and well-being. Therefore, I decided the service is Non-compliant with Requirement 3(3)(a).

*Requirement 3(3)(b):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer.

The site audit report noted:

* A consumer’s wound was not managed in accordance with their directives. Photographs of the wound did not include measurements, and a review of their wound monitoring chart indicated their wound dressing was not changed daily, for a period of two consecutive days, as required.
* A consumer’s care planning documentation indicated their falls and subsequent injuries were not always managed in accordance with the service’s fall management procedures.
* The care planning documentation for a consumer with a diagnosis of diabetes did not include assessment and directives from their medical officer with acceptable parameters for monitoring their blood glucose levels.

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* Concerning the consumer’s wound care management – An investigation of the findings advised the consumer’s wound dressing was changed on a daily basis; however, it was documented incorrectly on the consumer’s wound monitoring chart. The service identified the wound photographs were not in line with best practice and have taken the following actions to improve care and service delivery:
  + Training and education provided to staff regarding wound management.
  + Increased oversight of wound care by senior clinicians.
* Concerning the consumer’s fall management – The service elaborated and corrected some information provided by the Assessment Team pertaining to the timeliness of post-fall care, and evidenced the service responded in a timely and appropriate manner.
* Concerning the consumer’s diabetes management – The service has reviewed the care planning documentation of consumers with a diagnosis of diabetes to ensure their medical directives are current with appropriate ranges and guidance for staff to escalate findings that are outside of their parameters.

I have considered the information provided by the Assessment Team and the Approved Provider. The response outlined by the Approved Provider addressed the concerns raised by the Assessment Team and provided evidence which showed the service demonstrated the effective management of high impact or high prevalence risks associated with the care of each consumer. Therefore, having considered all relevant information, I decided the service was Compliant with this requirement.

*Requirement 3(3)(g):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate the minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection.

The site audit report noted:

* The Assessment Team observed a number of breaches in infection control procedures, including:
  + On several occasions, staff were observed to wear their face masks below their chins, and to touch the front of their face masks during observation rounds.
  + There was an absence of clinical waste bins near the service’s entrance to dispose of rapid antigen tests.
  + A staff member was observed exiting the room of a COVID-19 positive consumer and entering the main shared unit corridor, whilst still dressed in their full Personal Protective Equipment (PPE). The staff member was further observed to be in close proximity of another staff member and using their mobile device.
  + Multiple hand sanitiser stations located within the service did not have hand sanitiser available.

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* The service acknowledged there were PPE breaches and staff were not in line with infection control standards, the service has taken the following actions to address the issues, including:
  + Training and education provided to staff regarding infection control, COVID-19 precautions, antimicrobial stewardship and donning and doffing of PPE.
  + Individual follow up with staff members observed to be in breach of the service’s infection control precautions as well as ongoing monitoring of repeated breaches.
  + Maintenance staff requested to ensure all hand sanitiser stations are full, and to be monitored on an ongoing basis.

In reaching my conclusion, I considered the information presented by the Assessment Team and the Approved Provider. I acknowledge the actions taken by the Approved Provider to address the identified issues. However, at the time of the site audit, the service did not have appropriate infection control systems in place, nor were staff properly following procedures and policies regarding infection control. Due to the observations made by the Assessment Team, and the potential for these issues to result in the further spread of COVID-19 to other consumers, I consider that at the time of the site audit, the service did not demonstrate the minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection. Therefore, I decided the service is Non-compliant with Requirement 3(3)(g).

*The other Requirements:*

Staff described how they approached conversations with consumers regarding end of life care, bearing in mind consumers may at times not be comfortable to discuss their end of life preferences. Care planning documentation showed consumers’ end of life preferences were accessible via the electronic documentation system.

The service demonstrated deterioration or change in a consumer’s health, cognitive function or capacity was recognised and responded to in a timely manner. Consumers and representatives indicated staff were responsive to their needs, and representatives confirmed they were kept well informed of changes to the consumer’s health needs.

Consumers expressed their care needs and preferences were effectively communicated between their representatives and staff and they received the care they needed. Care planning documentation provided adequate information to support effective and safe sharing of the consumer’s information to support care.

Management and staff described the referral process used when referring consumers for consultation within and outside of the organisation. Care planning documentation demonstrated timely referrals to medical officers, allied health therapists and other providers of care and services.

# 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 indicated they were supported to engage in activities of their choice and explained how services and supports for daily living had improved their independence, health, well-being, and quality of life. Care planning documentation accurately identified consumers’ needs, goals and preferences.

Staff outlined the processes in place if they identified a consumer requiring supports to assist with their emotional, spiritual or psychological well-being. Care planning documentation identified information regarding the emotional, spiritual and psychological needs and preferences of consumers and the strategies to support as to how staff could assist them.

Consumers felt staff assisted them to participate in their community, within and outside of the organisation's service environment, have social and personal relationships and do things of interest to them. Care planning documentation identified what was important to consumers and included strategies to support their choices.

The service utilised an electronic care planning system and shift handovers to ensure consumers’ needs and preferences were shared. Consumers indicated staff were aware of their needs and preferences.

The service demonstrated timely and appropriate referrals of consumers to other organisations, individuals and providers of other care and services. Care planning documentation evidenced the service collaborated with external providers to support the needs of consumers.

Consumers and representatives indicated the service provided meals which were varied and of suitable quality and quantity. Staff demonstrated a familiarity with the dietary needs and preferences of consumers.

Consumers indicated they felt safe when using the service’s equipment and advised equipment was accessible and suitable for their needs. Staff explained how maintenance issues were reported through the service’s maintenance request system.

# 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

The service environment was observed to be calm, friendly and welcoming, with communal and private areas for consumers and visitors to use. Consumers felt comfortable within the service environment and felt a sense of belonging and independence.

Consumers were satisfied the service was clean, safe and well maintained, this aligned with observations made by the Assessment Team. Staff and consumers described what they would do in the event a hazard or safety issue was identified.

The Assessment Team observed furniture in the communal areas and consumers’ rooms was observed to be comfortable and suitable for purpose. Staff outlined how shared mobility equipment was sanitised between uses.

# 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

Consumers and representatives stated they felt comfortable and understood how to provide feedback or make complaints. The Assessment Team observed internal feedback and complaint forms were accessible within the service environment.

Consumers and representatives were aware of advocacy services and external complaint mechanisms. The Assessment Team observed posters and brochures regarding advocacy services on display within the service.

Management outlined complaints were adequately addressed and an open disclosure process was consistently applied. Staff demonstrated an understanding of the open disclosure process and explained how open disclosure was implemented in response to a complaint.

The service demonstrated all feedback was recorded and reviewed, and used to improve the quality of care and services. Management actively encouraged staff to record all feedback, whether formal or informal, to gather data and drive care and service improvements.

# 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

*Requirement 7(3)(c):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate the workforce was competent, and had the qualifications and knowledge to effectively perform their roles.

The site audit report noted:

* A consumer’s representative provided feedback that staff were not competent with dementia related care and did not effectively manage the consumer’s behavioural dementia symptoms.
* There were a lack of processes in place to determine staff competency for areas of knowledge for which training and education had been provided.
* The Assessment Team indicated staff did not demonstrate a shared understanding of clinical risks relating to consumer care which included pain, wound and fall management processes.

The issues, and Approved Provider’s response relating to pain, wound and fall management as it related to consumers was previously discussed under Requirements 3(3)(a) and 3(3)(b).

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* Concerning staff’s understanding of clinical risks – the service reiterated care was provided to consumers in line with their needs and best practice, and staff were competent to perform their roles.

I have considered the information provided by the Assessment Team and the Approved Provider. Whilst I acknowledge the service had demonstrated discrepancies with the competency and knowledge of staff to provide to deliver safe and quality care, these examples alone were insufficient to indicate significant deficits in the overall competency of staff. The response outlined by the Approved Provider addressed the concerns raised by the Assessment Team and evidenced the workforce had the qualifications and knowledge to perform their roles. Therefore, having considered all relevant information, I decided the service was Compliant with this requirement.

*The other Requirements:*

Management advised call bells were monitored monthly and when a concern was raised by consumers. Consumers and representatives generally were satisfied the workforce was planned to enable the delivery and management of safe and quality care and services.

The service demonstrated consumers’ identity, culture and diversity was identified and respected. The Assessment Team observed staff interacting with consumers in a kind and caring manner; this observation was consistent with feedback received from most consumers and representatives.

The service demonstrated there were systems in place to ensure the workforce was recruited, trained, equipped, and supported to deliver the outcomes required by these Quality Standards. Representatives generally felt confident staff had the appropriate skills and knowledge to ensure the delivery of safe and quality care and services.

Staff confirmed performance evaluations were completed annually, and described how an evaluation was an interactive process, where both management and staff had input into the review. Management described how staff were monitored and reviewed and how feedback from consumers was incorporated in their performance reviews.

# 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

*Requirement 8(3)(d):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate effective risk management systems and practices, including the management of high impact or high prevalence risks associated with the care of each consumer.

The site audit report noted:

* There were deficits regarding the management of high impact or high prevalence risks, associated with the care of consumers, which included the management of restrictive practice documentation, and pain, wound and fall care.

The issues, and Approved Provider’s response relating to pain, wound and fall management as it related to consumers was discussed under Requirements 3(3)(a) and 3(3)(b).

In its response, the Approved Provider included additional information regarding the issues identified by the Assessment Team.

The response advised:

* The service acknowledged there were areas for improvement within the service, and the issues identified by the Assessment Team were isolated incidents and not attributed to organisational or systemic failures.

I have considered the information provided by the Assessment Team and the Approved Provider. Whilst I acknowledge the service has demonstrated discrepancies with service’s risk management systems and practices, on the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate a systemic organisational governance failure of the service’s risk management systems and practices. Therefore, I decided the service was Compliant with this requirement.

*The other Requirements:*

Consumers and representatives provided examples of how they were involved in the development, delivery and evaluation of care and services, including through consumer meetings. The Assessment Team observed feedback forms and a suggestion box was accessible by consumers, representatives and staff.

Management demonstrated how the Board, and the governing bodies promoted a culture of safe, inclusive, and quality care and services. The Board formally met once a month and reviewed reports from the clinical governance committee, complaints committee and medication advisory committee.

The organisation demonstrated effective governance systems which provided oversight across key areas such as information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaint management. There were reporting mechanisms in place to guide improvements and changes as well as inform senior management within the organisation.

The service had a clinical governance framework and supporting polices in place which addressed antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff demonstrated an understanding of antimicrobial stewardship and open disclosure practices.

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)