Performance

Report

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| Name of service: | Uralba Hostel |
| Service address: | 50 Tor Street GUNDAGAI NSW 2722 |
| Commission ID: | 0285 |
| Approved provider: | Gundagai and District Hostel Accommodation Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 April 2023 |
| Performance report date: | 23 May 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 Uralba Hostel (**the service**) has been prepared by J Durston, 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 Assessment Contact - Site; the Assessment Contact - Site 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 26 April 2023.
* the Performance Report dated 20 April 2022 following the Site Audit undertaken from 1 February 2022 to 3 February 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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 approved provider ensures assessment and planning for consumers, including those in respite care, is based on assessment of their current needs, and assessments and care plans are regularly reviewed and updated, including when the consumer’s condition changes and/or deteriorates or an incident occurs.

* Requirement 2(3)(a) - the approved provider ensures the new incident forms and risk assessment tool are implemented and reviewed for effectiveness in relation to accurate calculation of level of risk and inclusion and implementation of effective risk prevention strategies in consumer care plans.
* Requirement 3(3)(a) – the approved provider ensures each consumer receives safe and effective personal and clinical care to meet their needs that is provided by staff who hold qualifications and have extensive training in the delivery of clinical care, in areas such as falls management and prevention, behaviour support and minimisation of restrictive practices, pain management and diabetes management.
* Requirement 7(3)(d) – the approved provider ensures all staff receive training in the minimisation of restrictive practices, including all types of restraint and effective development and use of responsive behaviour support plans.
* Requirement 7(3)(d) – the approved provider ensures it has sufficient staff with clinical expertise to provide regular, effective assessment, planning, management, monitoring and review of consumers’ clinical care needs, to deliver best practice clinical care, and to provide effective clinical oversight to ensure clinical compliance with the Aged Care Quality Standards.
* Requirement 8(3)(e) – the approved provider ensures that it has in place an effective incident management system that includes key aspects such as investigation to identify contributing factors, reassessment of consumers following incidents, review of existing and development of new preventative measures, key roles, responsibilities and accountabilities for incident management and the clinical oversight and overall governance process for incident management.
* Requirement 8(3)(e) – the approved provider has a clinical governance framework in place that ensures an effective clinical oversight process is in place, including regular updates provided to the Board on clinical incidents, indicators, risks and trends; and the Board is involved in overseeing clinical issues and risks are resolved, prevention strategies are actioned and reviewed for effectiveness.

# 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 |

Findings

The service was previously found non-compliant in Requirement 2(3)(a) following a Site Audit conducted on 1 February 2022 to 3 February 202 that identified issues regarding risks associated with restrictive practices and lack of risk assessment plans.

An Assessment Contact was conducted on 4 April 2023. The Assessment Team found the service has implemented some improvements to assessment and planning in response to the information raised in the 2022 Site Audit Report. In relation to restrictive practices, the service has introduced a psychotropic register for consumers receiving psychotropic medication, maintained by the medical officer. Management attended restrictive practices training. The service has also introduced a risk assessment including a risk matrix care plan to document risks consumers wish to take.

The Assessment Team identified that management with Certificate III level qualifications, conduct assessments and care planning for consumers. However, a registered nurse qualification is the required level of clinical expertise to perform those functions. There is no process for regular assessment and review, including when incidents occur and when there are changes in the consumer’s condition. Care plans reviewed did not reflect the current needs of consumers in areas such as falls assessment, management, mobility and skin integrity and behaviour support. The care plan of one consumer who had a fall in January 2023 showed the last assessment for mobility and falls risk occurred in 2019. The skin tear sustained by the consumer in the recent fall was not recorded in their skin care plan. One consumer admitted to the service for respite care post hospital discharge was assessed by the hospital as being a high falls risk with difficulty moving from sit to stand and stand to sit positions due to a diagnosed condition. However, the consumer was assessed by a Certificate III qualified manager at the service as a medium falls risk and independent in relation to sit to stand and stand to sit.

In relation to restrictive practices, the Assessment Team identified gaps in management of behavioural support and restrictive practices at the service, including not updating the behaviour support plan when there was a change in consumer’s behaviour, generic rather than personalised behaviour support strategies in the behaviour support plan, no behaviour monitoring or non-pharmacological behavioural support strategies tried before psychotropic medication was prescribed.

The Assessment Team found care plans are developed for each consumer. However, the service does not undertake assessments for respite consumers, whose care plans are based on My Aged Care assessments completed sometime in the past. Hence care plans for respite consumers may not reflect their current needs.

The service had introduced a multi-level risk matrix in its assessment process, but it was unclear how the risks were calculated. All risk assessment plans reviewed by the Assessment Team had high risk ratings for all risks and plans lacked strategies to prevent risks. When this was raised with management, they commenced development of a more detailed risk assessment tool and contacted the service’s peak body for advice. Review care documentation for three consumers who had falls between January and March 2023, showed post incident investigations did not to identify contributing factors and future falls prevention strategies.

In their response to the Assessment Team report the service outlined improvements made to address the gaps identified in relation to assessment and planning with consumers. The service provided a list of actions taken to review, assess and update each of the named consumers’ care plans to reflect their current needs, including improved risk assessments and identification of mitigation strategies. New accident and incident forms were also completed for relevant consumers. The named consumer’s health summary and psychotropic register were amended by the medical officer to include the condition being treated by the prescribed psychotropic medication. The consumer’s behavioural support plan was updated to reflect their recent behavioural changes.

The service advised new respite consumers are now interviewed on admission and an in-depth interim care plan is formulated around their current health needs. Their consumer medication profiles and current health summary are sourced prior to admission to assist with the assessment process. Care planning policy and procedures have been updated to include 4 monthly reviews and assessments to identify risks, which will also occur in the event of deterioration, incidents or change of the consumer’s health status, that will be signed off by the registered nurse.

I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the actions taken by the service to address the gaps in care planning in relation to the consumers identified in the Assessment Team report. However, I note that it will take some time for these improvements to be embedded into usual practice. Accordingly, I find the Requirement 2(3)(a) is non-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. | Non-compliant |

Findings

The service was previously found non-compliant in Requirement 3(3)(a) following a Site Audit conducted 1 February 2022 to 3 February 2022 that identified gaps in access to and communication with appropriately skilled medical professionals to meet the personal and clinical care needs of consumers.

An Assessment Contact was conducted on 4 April 2023. The Assessment Team found the service has made improvements regarding the involvement of and communication with appropriately skilled medical professionals. Consents are now obtained from consumers on admission to the service, for the provider to communicate with medical officers on their behalf. Most medical officers now provide written notes following review of consumers. Medical notes are reviewed weekly by management who follow-up issues identified with the medical officer. Clinical documentation generally showed regular communication with medical officers and demonstrated involvement of the community nurse in complex wound care. Management advised they can access a range of allied health professionals from the local community health service when referrals are recommended by the medical officer.

However, clinical and personal care delivery is not always informed by assessment of the consumer’s needs by suitably qualified professionals and does not always identify risks or develop risk mitigation strategies which impacts on the ability of staff to provide safe and effective care. This was considered in Requirement 2(3)(a). However, the lack of clinically qualified staff also has a significant and direct impact on clinical care delivery. Some gaps were found in clinical monitoring and escalation in areas such as diabetes management. Oversight of clinical care is currently undertaken by management staff who do not hold qualifications in, and have not had extensive training, in relation to delivery of clinical care.

The Assessment Team found that 2 months before the Assessment Contact the service employed a registered nurse to work 1 day per fortnight, but their scope of involvement in clinical care and oversight had not been formalised, a position description and duty statement had not been developed.

In their response to the Assessment Team report, the approved provider advised that in relation to clinical monitoring and escalation for one consumer, the service had contacted the hospital on 2 occasions and was advised by hospital staff that unless the consumer was unwell, they could continue to monitor them. The service also advised the medical officer‘s notes dated 30 March stated there was no need for action if the consumer remained well. On 20 April 2023 the consumer’s care plan was updated with clearer instructions for staff to follow if their condition changed.

I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the actions the service has taken to improve involvement and communication with appropriately skilled medical professionals. I recognise the service twice sought medical advice regarding a change in a consumer’s condition and received similar advice from the hospital and medical officer to continue to monitor the consumer unless they became unwell. The Assessment Team report noted that during the Assessment Contact a Board member described consumers at the facility as having low care needs. However, the service is responsible for providing nursing care and respite care. To date the service has not sufficiently addressed the need to ensure its workforce has the appropriate clinical expertise at the registered nurse level to provide regular, effective assessment, planning, management, monitoring and review of consumers’ clinical care needs; and to provide the standard of clinical oversight required to maintain best practice clinical care delivery. Accordingly, I find requirement 3(3)(a) non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |

Findings

The service was previously found non-compliant in Requirement 7(3)(d) following a Site Audit conducted 1 February 2022 to 3 February 2022 that identified staff were not sufficiently trained and equipped to ensure minimisation of the use of restrictive practices.

An Assessment Contact was conducted on 4 April 2023. The Assessment Team found the organisation has purchased Serious Incident Response Scheme education resources for online education of staff. Training on minimising use of restraint was added to the service’s annual mandatory education requirements. Review of the annual mandatory education matrix shows that while all staff have completed most of the mandatory education topics, only 20 percent of staff have completed the required education about SIRS in the past 12 months. Management advised only a few staff have completed the modules.

The Assessment Team identified the manager and deputy manager, hold Certificate III level qualifications, and are responsible for all assessment and care planning for consumers at the service. In addition, they provide oversight of care staff. Management confirmed they had not had specific training to undertake these responsibilities, but said they completed online education about clinical care to assist develop and maintain their skills. Training records showed that in 2022 the managers completed 2 training sessions on aspects of clinical care. The level of clinical expertise at the service has been considered in Requirements 2(3)(a) and 3(3)(a).

In their response to the Assessment Team report, the approved provider advised that at the time of the Assessment Contact their compulsory education records from 2022 were not properly updated, and the paperwork was archived. The service has since retrieved the documents and the 2022 compulsory education records have been updated to include 16 staff who attended a SIRS training toolbox session on delivered by the manager on 10 May 2022. All staff have now completed an online SIRS training module in 2023. All new staff are required to complete the SIRS modules on the Commission’s eLearning system, and all compulsory education. The registered nurse has completed all current education and is currently completing an immunisation course.

I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the increased mandatory training completions at the service, evidenced in the amended training records provided in the service’s response; and that the service has recruited a registered nurse for 2 days per fortnight and is trying to recruit for further registered nurse hours. However, I find the Assessment Team report more compelling regarding the continued lack of sufficient and regular clinical expertise at the service to provide effective clinical care and services to meet consumers’ needs and minimise risk. Lack of training on minimising use of restraint was identified as a gap in the 2022 Site Audit report. The assessment Team reported this was added to the service’s annual mandatory education requirements. However, the service did not provide evidence in its response to show staff had completed comprehensive training in in this area, except for a mandatory training attendance record for one course titled ‘chemical training,’ and it was unclear what this course covered. Accordingly, I find Requirement 7(3)(d) non-compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Non-compliant |

Findings

The service was previously found non-compliant in Requirement 8(3)(e) following a Site Audit conducted 1 February 2022 to 3 February 2022 that identified lack of effective processes to minimise the use of restraint and failure to ensure the service’s restrictive practices policy was up-to-date.

An Assessment Contact was conducted on 4 April 2023. The Assessment Team found gaps regarding failure to develop and implement an effective clinical governance system. The service does not have a process for clinical oversight. Review of a recent management report to the Board showed it did not contain specific clinical data or other aspects of clinical governance. However, the service sends clinical data to the National Quality Indicator Program. The service’s clinical governance framework notes there are clear responsibilities for managing safety and quality of care, monitoring and data collection, and that the governing body will delegate responsibility to staff and management to implement clinical governance arrangements and provision of safe and quality clinical care. However, actual clinical governance processes are not specified in the document.

The Assessment Team found that following the site Audit in 2022, the service updated their restrictive practices policy, and developed policies and procedures for incident management and the Serious Incident Response Scheme (SIRS). However, incident reports from the last three months did not demonstrate effective clinical oversight of incident management and that key aspects of an effective incident management system are in place, including investigation to identify contributing factors, reassessment of consumers following incidents, review of existing and development of new preventative measures.

In their response to the Assessment Team report that included the service’s plan for continuous improvement, the approved provider advised that the manager’s report to the Board has been updated to incorporate clinical care issues to be discussed at Board meetings. A report containing all clinical data has been developed to present to the board on a monthly basis. The incident and accident form has been updated and all incidents will be discussed at staff and Board meetings. The Board is currently seeking an Allied Health Team to form a clinical governance team. The service is currently advertising to recruit more registered nurses but noted difficulty in filling the roles consistent with the industry as a whole. The service is investigating options such as hiring agency nurses, but advised this would be a last resort due to the expense. The provider has developed a job description for the registered nurse recently employed by the service for 2 days per fortnight.

I have considered the Assessment Team’s report and the approved provider’s response. I commend the actions the service has taken and that it plans to take as outlined in its plan for continuous improvement, to address the Assessment Team’s findings in relation to clinical governance. However, I consider those improvement actions will take time to demonstrate effectiveness and sustainability. Accordingly, I find Requirement 8(3)(e) non-compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)