Performance

Report

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| Name: | Victoria Park Hostel |
| Commission ID: | 7090 |
| Address: | 1 Croesus Street, KALGOORLIE, Western Australia, 6430 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 27 August 2024 |
| Performance report date: | 23 September 2024 |
| Service included in this assessment: | Provider: 896 Southern Cross Care (WA) Inc  Service: 4618 Victoria Park Hostel |

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 Victoria Park Hostel (**the service**) has been prepared by J Wilson, 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.

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the assessment team’s report received 17 September 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not fully assessed |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully assessed** |

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

# Areas for improvement

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |

Findings

Consumers confirmed they are involved in assessment and planning of their care and services. Management and staff described, and care documentation confirmed, assessment and planning processes which include the assessment of risks to consumers’ care. Care documentation evidenced the use of validated assessment tools in the assessment of risk, with staff knowledgeable of consumers’ risks and the mitigation strategies in place to support consumers.

Based on the assessment teams report, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers complaint.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Consumers expressed satisfaction with the care provided and felt safe and comfortable. Staff were knowledgeable about the needs of consumers, including the risks associated with their care, and the mitigation strategies in place. While the assessment team’s report noted two consumers’, who have since relocated to the co-located service, did not have their changed behaviours effectively managed, the assessment team’s report did not provide evidence to support consumers’ changed behaviours were not being effectively managed. In addition, the strategy of transferring both consumers to another co-located service supports my view staff recognised both consumers’ care and service needs and tailored the provision of personal and clinical care to a more suitable staffing and service environment. Care documentation included high impact risks are identified, escalated with mitigation strategies implemented and evaluated to reduce the risk of recurrence. Service documentation includes a suite of policies and procedures in place to guide staff practice in the management of risks to consumers’ health and well-being.

Based on the assessment teams report, I find Requirement (3)(b) in Standard 3 Personal care and clinical care compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

The assessment team recommended Requirement (3)(d) not met as they were not satisfied an effective incident management system was in place to manage risk. The assessment team’s report included the following evidence relevant to my finding:

* Behaviour related incidents for 2 named consumers were not consistently recorded through the incident management system to ensure incidents were review and analysed to ensure prompt escalation of concerns related to behaviour management.
* One consumer’s escalating behaviour towards staff had not been recorded through the service’s incident management system, and therefore, had not been identified and escalated to trigger additional support.
* Management acknowledged staff did not consistently recognise verbal insults as an incident type that is required to be recorded.
* One incident occurred in June 2024, where staff were locked in an office due to the changed behaviour of a consumer, was not reported through the incident management system. The incident was reported as a work health safety issue.

The provider’s response acknowledged the deficits in the incident management system identified. The provider’s response included the following information and improvements implemented relevant to my finding:

* The provider acknowledged staff were not consistently recording behaviours on consumer behaviour charts as they had perceived the consumer’s behaviours as normal. Education and training had been provided in April, May and June 2024. Training records provided for April 2024 confirmed 23 staff attended training.
* The incident management system is used to report new and escalating behaviours, while known behaviours are documented on behaviour charting.
* Weekly multi-disciplinary team meetings commenced on 6 September 2024 where incidents and concerns from the previous week are escalated and discussed.
* All staff meeting minutes dated February 2024, April 2024, and May 2024 include discussions on consumers with changed behaviours, and health or clinical issues of concern.
* Training records provided showed de-escalation training was provided to clinical and care staff on 11 July 2024.
* Management confirmed the incident occurring in June 2024 was documented in the consumer’s behaviour charting.
* The provider described management reviewed the consumer’s behaviour charting and identified the environment of the service as a contributing factor in his escalation of behaviours; however, evidence of this review was not provided.

I acknowledge the information in the assessment team’s report; however, I have come to a different view. In coming to my finding, I have considered the training records provided, which demonstrate the provision of training to staff in relation to documentation and behaviour support and note there have been no issues with the documentation or reporting of incidents through the Service’s incident management system identified since June 2024. Additionally, the Service implemented additional monitoring processes following the assessment contact, inclusive of weekly multi-disciplinary huddles, following the assessment contact, to further strengthen management’s oversight and reporting processes.

I am satisfied the Service has effective risk management processes in place as the evidence in the assessment team’s report, and the provider’s response demonstrates the Service self-identified and implemented corrective actions prior to the assessment contact in August 2024, which improved staff practices with no additional issues identified since June 2024. In addition, evidence in Standard 2 and Standard 3 supports my view that there are effective processes to support the management of high impact and high prevalence risks, and staff have access to incident reporting processes to identifying and respond to abuse and neglect. Therefore, I find Requirement (3)(d) in Standard 8 Organisational governance 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)