Performance

Report

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| Name of service: | Performance report date: |
| Vietnam Veterans Keith Payne VC Hostel | 14 July 2022 |
| **Commission ID:** | **Activity type:** |
| 0309 | Site audit |
| **Approved provider:** | **Activity date:** |
| Central Coast Community Care Association Limited | 31 May 2022 to 2 June 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 Vietnam Veterans Keith Payne VC Hostel (**the service**) has been considered by Kathryn Spurrell delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 29 June 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 | **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 | **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 3(3)(a) – The service ensures that 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)(c) – The service ensures the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.
* Requirement 3(3)(g) – The service ensures the minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection.
* Requirement 7(3)(e) – The service ensures that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Requirement 8(3)(c) – The service ensures it has effective organisation wide governance systems relating to information management and workforce governance.
* Requirement 8(3)(d) – The service ensures it has effective risk management systems and practices in place.

# Standard 1

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

## Findings

Consumers and representatives confirmed staff were kind and treated them with dignity and respect, with their identity, culture and diversity valued. Staff spoke of consumers in a respectful manner and demonstrated an understanding of their identity, culture and individual values.

Staff described how the cultural, spiritual and personal preferences of consumers influences the delivery of care and services. Consumers expressed they felt safe within the service and staff respected their individual 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. Staff described the various ways consumers are supported to make informed choices about their care and services on a day-to-day basis.

Management and staff were aware of consumers that choose to engage in activities with an element of risk, as well as the strategies in place to limit the risk posed to consumers. Consumers were able to describe the ways the service supports them to take risks to enable them to live the best life they can.

Consumers and representatives confirmed they received information about the care and services available to them upon entry to the service. The Assessment Team observed menus, activity calendars and visiting service information on display throughout the service.

Consumers and representatives confirmed their privacy and confidentiality is respected. The Assessment Team observed staff knocking on consumers doors and waiting for an answer prior to entering consumers’ rooms. Staff were observed greeting consumers in a quiet and respectful manner.

# Standard 2

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

## Findings

Care planning documentation evidenced assessments are completed to identify the needs, goals and preferences of consumers upon entry to the service. Consumers and representatives expressed satisfaction with the service’s assessment and care planning process.

Care planning documentation evidenced consultation, including advanced health directives and management and staff described how the service engages with consumers and representatives regarding end-of-life planning and palliative care.

Consumers described how family and representatives are involved in the assessment and care planning process on an ongoing basis. Care planning documentation demonstrated this ongoing involvement, and input from relevant health professionals when required.

Consumers and representatives confirmed the outcomes of assessment and planning have been communicated and are able to access consumer care plans upon request. Staff advised they have access to consumer care plans when they are providing care through the electronic care management system and their hand-held devices.

Care planning documentation confirmed care plans are reviewed on a regular basis and when the consumer’s circumstances have changed, or incidents have occurred. Staff were aware of the incident reporting process and how these incidents may trigger the need for a reassessment of the consumer’s care and services.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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

The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

* 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.

The Site Audit Report identified deficits in the service’s ability to ensure the delivery of safe and effective care and services. Summarised relevant evidence included:

The service was unable to consistently demonstrate it monitored, managed, and reviewed pain to provide effective pain relief for two named consumers and documentation for a named consumer subject to mechanical restraint did not evidence two-hourly check-ups as required.

The Assessment Team observed that heat packs were given to consumers with moderate to severe cognitive impairment and was noted they may be at risk of burns as they may not be able to communicate if the heat pack was too hot. The relevant policy did not consider if this group of consumers could safely manage their own heat pack.

In the written response of 29 June 2022, the Approved Provider outlined that in relation to:

The named consumer subject to mechanical restraint; the service acknowledged that staff were unable to provide evidence of two-hourly check-ups at the time of the Site Audit. However, provided physical evidence to demonstrate that checks and care had been undertaken and provided to the consumer in line with directives.

The service acknowledged there were identified gaps in the pain management of the two named consumers and outlined the actions that have been taken to rectify these gaps as well as the proposed actions.

The service’s heat pack policy; the service’s process for heat pack allocation is currently assessed by physiotherapy staff. Consumers are reviewed for the suitability to use heat packs, using heat/cold testing which is documented in the pain assessment for each consumer. The heat pack policy states that heat packs can only be used on consumers who are able to provide adequate and appropriate feedback.

I acknowledge the additional explanation and undertakings provided by the service; however, based on the totality of evidence, find that at the time of the Site Audit, the service did not demonstrate effective delivery of best practice care and services. Therefore, I find requirement 3(3)(a) is non-compliant.

The Site Audit report identified deficiencies in the needs, goals and preferences of consumers nearing the end of life being recognised and addressed, the Assessment Team inspected the end-of-life care documentation for a recently deceased consumer and found the consumer’s pain was not effectively managed nearing end-of-life. The Assessment Team noted the medical officer prescribed end-of-life analgesia however staff did not provide it in a timely manner and were unable to show how they maintained effective pain relief. Staff described the consumer indicating they were in pain especially during repositioning.

In its written response, received 29 June 2022, the Approved Provider acknowledged there were identified gaps in the palliative care provided to the consumer and detailed the actions taken by the service to ensure pain and symptoms of palliation are regularly monitored and identified. The service further detailed that it planned to provide staff with additional palliative care training.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding effective end-of-life care, the service did not demonstrate effective processes at the time of the Site Audit. Therefore, I find requirement 3(3)(c) is non-compliant.

The Site Audit report brought forward the following evidence relating to the minimisation of infection related risks reported by the Assessment Team included:

Staff advised they often utilised the cakes of soap within the rooms of consumers to wash their hands when providing care as there is nowhere else to do so. At the time of the Site Audit, the Assessment Team raised this with management, who advised, handwashing stations have been ordered for the rooms of all consumers.

The Assessment Team observed there were insufficient directives provided at the front entrance regarding COVID-19 protocol and there was no hand sanitiser available for visitors until they had already entered the service.

Staff were observed to be sharing mobility equipment among consumers.

A staff member was observed to demonstrate unhygienic cleaning practices.

The Approved Provider’s written response, received 29 June 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

Staff using cakes of soap within the rooms of consumers; the service has completed an audit of the hand sanitising stations and additional stations have been placed throughout the service. Soap and shampoo dispensers have been allocated in all the rooms of consumers to replace cakes of soap.

The Assessment Team’s observations regarding the entrance of the service; the service acknowledged there were improvements to be made in the front entrance to the service. A review has been undertaken and improvements made on the day of the assessment visit, including additional hand sanitising station prior to reaching the desk.

The Assessment Team’s observations regarding staff sharing mobility equipment among consumers; the service acknowledged there were not individually assigned resident slings and have since allocated consumers their own set of slings.

A staff member observed to demonstrate unhygienic cleaning practices; The service acknowledged the staff member was operating outside of policy and procedure related to infection control practices. The staff member was not using the advised cleaning method or recommended cleaning equipment on the day. The service reiterated that this is not indicative of staff practice.

While I acknowledge the Approved Providers response, I have considered the totality of evidence in the Site Audit report and I am not satisfied the service demonstrated effective practices in relation to the minimisation of infection related risks. Therefore, I find requirement 3(3)(g) is non-compliant.

I am satisfied that the remaining four requirements of Quality Standard 3 are compliant.

The service provided evidence to demonstrate effective management of risks relating to the care of consumers in response to evidence brought forward by the Assessment Team and evidenced appropriate risk management of weight loss, pain management and referrals to external care providers where appropriate.

Deterioration or changes in a consumer’s health is recognised and responded to in a timely manner, as confirmed by care planning documents reviewed by the Assessment Team. Staff described examples regarding how they recognised and responded to consumers’ health deterioration.

Representatives indicated the service provides regular communication between consumers, representatives and allied health professionals and are satisfied the consumer’s condition, needs and preferences are documented. Staff demonstrated that changes in the care and services of consumers are communicated within the service through progress notes and handover processes.

Care planning documentation evidenced timely referrals to medical officers, allied health therapists and other providers of care and services. Staff described how recommendations made by visiting allied health providers are documented within the consumer’s progress notes and care plan.

# Standard 4

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| Services and supports for daily living | | Compliant |
| 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 and representatives felt that consumers received safe and effective services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life. Care planning documentation included information of what care and services are important to consumers and the supports needed to engage in these activities.

Consumers and representatives expressed that the service provides support for daily living to promote the emotional, spiritual and psychological well-being for each consumer. Care planning documentation included information about the emotional, spiritual and psychological needs of consumers and the strategies in place to support these needs.

Care planning documentation included information about the interests of consumers and detailed the supports that assisted consumers to participate in their community, within and outside of the organisation's service environment, have social and personal relationships and do the things of interest to them. The Assessment Team observed consumers leaving the service with their friends and family.

Consumers and representatives reported that information about their daily living choices and preferences is effectively communicated throughout the service, and staff understand their needs and preferences. The Assessment Team observed a shift handover and noted staff were communicating information about the consumers’ care needs and preferences.

Care planning documentation demonstrated the occurrence of timely and appropriate referrals to individuals, other organisations and providers of other care and services. Staff demonstrated a shared understanding of the external supports utilised by consumers and could identify the supports and external organisations available to consumers if requested.

Consumers and representatives mostly expressed positive feedback regarding the quality and quantity of the meals provided by the service. Care planning documentation outlined the dietary requirements and preferences of consumers as well as if they required assistance during meals.

The Assessment Team observed that where equipment was provided, it was safe, suitable, clean, and well maintained and that staff undertook ongoing monitoring to ensure equipment was fit for purpose. The service conducts regular inspections on all equipment to ensure operational integrity and safety.

# Standard 5

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

## Findings

Consumers and representatives said the service environment is welcoming and feels like home. Consumers’ room are personalised with photographs, decorations and other items of importance. The service environment was observed to be welcoming and reflected dementia enabling principles of design. Consumers, including those using mobility aids, were observed to be freely mobilising around the service. Each consumer’s room has an unlocked door to enable free access to their own veranda and outdoor areas. Outdoor areas were observed to be equipped with tables and chairs, and external pathways were observed to be clear of trip hazards.

Consumers and representatives said the service environment, furniture, fittings and equipment are safe, clean and well maintained. Preventative maintenance checks and scheduling of major maintenance takes place, as well as reactive maintenance in response to feedback from consumers and staff. Staff described how they register maintenance requests. Logs reflected that regular cleaning and maintenance occurs.

**Standard 6**

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

## Findings

The Assessment Team recommended the following requirement was not met:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team brought forward evidence from consumers and staff relating to the ineffective tracking and recording of complaints and found that feedback and complaints were not being consistently reviewed by management and used to improve care and services. Their recommendation relied on feedback received from staff who described inconsistent processes for recording feedback, data that showed no complaints were recorded in two of the months prior to the Site Audit and differing information provided to the Assessment Team throughout the Site Audit derived from the complaints register.

In its response dated 29 June 2022 the Approved Provider disagreed with the findings of the Assessment Team. It advised complaint trends are reviewed and updated monthly as part of the High Impact High Prevalence Monthly Clinical Risk Report. High risk complaints are escalated to the Board prior to submission of the care governance report. The process for recording complaints is included in the new Feedback Policy. The Approved Provider noted the absence of complaint data for April and May 2022 reported by the Assessment Team is correct, as no complaints were received during these months - suggestions and compliments were received and recorded during this time.

In relation to feedback being used to improve the quality of care and services, the Approved Provider provided evidence of several improvements, including improvements to the call bell system. In its response, the Approved Provider committed to follow up with all consumers who made complaints in 2022 to ensure satisfaction with resolution of the complaint.

I have considered the totality of evidence brought forward by the Assessment Team and the Approved Provider in its written response and I am satisfied the Approved Provider is meeting its obligations in relation to Requirement 6(3)(d).

I am satisfied that the remaining three requirements of Quality Standard 6 are compliant.

Most consumers and representatives felt comfortable and encouraged by the service to provide feedback and make complaints and explained they could do so by speaking directly to staff, completing feedback forms and attending resident meetings. Staff described how they support consumers to provide feedback and make complaints and demonstrated understanding open disclosure. The Serious Incident Response Scheme register demonstrated that appropriate and timely action is taken, including an open disclosure process, when incidents occur.

The Assessment Team identified the service could not provide evidence of verbal and paper complaint records, and that it is reviewing the policy for documenting verbal, informal and formal complaints. In its response, the Approved Provider confirmed that all feedback is logged in the feedback register, regardless of how it is received. It also advised that the feedback policy is not under review, but the feedback form had been revised and distributed.

Staff demonstrated awareness of how to access interpreter and advocacy services for consumers. The Assessment Team observed feedback forms, posters for raising complaints externally and brochures for advocacy and language services were displayed in the communal area of the service.

**Standard 7**

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| Human resources | | Non -compliant |
| 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. | Non -compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team brought forward evidence that regular performance assessment of each member of the workforce was not undertaken. Relevant (summarised) evidence included:

Some staff could not recall when their last performance appraisal was undertaken.

One staff member stated they had not had a performance assessment in over 2 years.

The service could not provide evidence of a schedule of performance assessment or of completed appraisals.

Management told the Assessment Team that staff performance is monitored through competencies, such as medication administration and manual handling, through the analysis of clinical data and consumer feedback. The service advised that performance issues identified through these monitoring mechanisms are addressed immediately and trigger a performance review for relevant staff.

In its written response of 29 June 2022, the Approved Provider advised it was under new management from December 2021 and that a new appraisal system will be implemented in July 2022. The Approved Provider acknowledged that performance appraisals may not have been completed for all staff over the past 12 months, noted it has developed a new paper-based performance appraisal tool to be used while a new online system is developed and undertook that they will all be up to date by the end of 2022.

Having considered the evidence brought forward by the Assessment Team and the Approved Provider, I find Requirement 7(3)(e) is non-compliant.

I am satisfied that the remaining four requirements of Quality Standard 7 are compliant.

Consumers and their representative said staff are kind, caring and gentle when providing care. Staff felt supported by management and had adequate time to complete their duties and provide care and services to consumer. The Board limited new admissions to the service during COVID-19 to maintain the provision of safe levels of care to residents. The service has processes in place to manage unplanned leave. Staff were observed interacting with consumers in a respectful manner.

The service has processes to recruit qualified and capable staff, and staff participate in an induction and onboarding process upon commencement. Position descriptions ensure key competencies and registrations are applied to each role. Management described how staff errors are handed.

Staff described training they had completed, and how they are alerted when training is due. Staff described the buddy system used to support new staff when they commence at the service. Training records and an online learning platform were observed.

**Standard 8**

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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.

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.

The Assessment Team brought forward evidence of ineffective policies and procedures to manage and communicate information about consumers’ care or changes in condition at an organisation level that impacted the delivery of safe care and the service’s governance was not effective in conducting regular staff performance assessment. Relevant (summarised) evidence included:

* The service’s inability to efficiently provide requested information in a timely and effective manner.
* Representatives who described issues with the sufficiency of communication from the service and support accessing care from external providers.
* A care staff said communication between allied health professionals and registered staff was not always clear and care staff sometimes had to inform the kitchen regarding changes in consumers’ diet.
* The vacant infection prevention and control lead position.

In its response to the Site Audit report dated 29 June 2022, the Approved Provider disagreed that there was a delay in providing records and information, nor that communication across the service was unclear and described various channels that information is communicated across the service, noting that at times this included verbal.

The Approved Provider noted it is aware of its governance responsibilities to provide performance appraisals and has completed work to improve the appraisal system since a recent change of ownership. It advised a new Human Resources team has been established to oversee and manage relevant tasks and processes, including the appraisal system, the Approved Provider further noted that the recently appointed infection prevention and control leads had left the service and a recruitment exercise was underway to identify a suitable candidate.

I agree with the Assessment Team that the organisation wide governance systems relating to information management and workforce governance were ineffective at the time of the Site Audit and find Requirement 8(3)(c) is non-compliant.

The Assessment Team brought forward evidence that the service did not have an effective risk management system, or effective and consistent policies and procedures to guide staff practice in identifying, managing and mitigating risks. Relevant (summarised) evidence included:

* Consumers with weight losses exceeding 3 months with no referrals made to speech pathologists or medical officers.
* An expired Nutrition and Hydration Policy.
* An absence of fireproof blankets in each designated smoking area, which was non complaint with the organisation’s own Smoking Policy. Five fire blankets were installed once this issue was raised with management.
* There was an absence of systems and processes to ensure staff monitor, review and manage pain effectively, including documenting the effectiveness of pain-relieving strategies. This is considered further under Requirement 3(3)(a).
* A Registered Nurse downgraded a consumer’s diet to regular and thin fluids without consulting a speech pathologist. A Medical Officer was consulted and the consumer completed a dignity of risk form.

In its written response of 29 June 2022, the Approved Provider stated it has a comprehensive risk identification system that includes monthly audits, including weight loss and pain management. A monthly report is prepared following the audit to identify issues, action plans, clinical indicator numbers, trends and other relevant information. The report is reviewed at a monthly meeting and relevant information communicated to registered staff.

The Approved Provider acknowledged that improvements are required in relation to pain and weight loss management, and these issues were identified through the monthly clinical risk report and Care and Governance Committee. The Approved Provider attached the April 2022 clinical risk report to its written response, which included consumer weight loss data, referral information, trends and action such as ensuring relevant referrals are made. The Approved Provider considers its risk systems had effectively identified these areas for improvement, risks had been reported and action planned to address the issues, prior to the Site Audit.

While I accept the actions implemented by the Approved Provider, at the time of the Site Audit there were ineffective systems and processes in place to ensure staff manage pain effectively and manage other high impact or high prevalence risks such as weight loss and swallowing difficulties for named consumers. I find Requirement 8(3)(d) is non-compliant.

I am satisfied the remaining three Requirements in Standard 8 are complaint.

Consumers and representatives are confident the service is run well, and are satisfied with their engagement in the development, delivery and evaluation of care and services. Staff described how consumers are encouraged to be engaged and involved in decisions about their services, such as through consumer meetings, case conferences, the use of feedback forms and informal gatherings.

Management described how the Board considers relevant information regarding changes at the service through regular meetings. Minutes reviewed by the Assessment Team evidence the Board considered strategies for strengthening governance, clinical indicators and COVID-19 outbreak management. The Board is aware of legislative change through subscribing to mailing lists from relevant organisations.

The service demonstrated the organisation’s clinical governance systems and framework ensure the quality and safety of clinical care, and promoting antimicrobial stewardship, the minimisation of restrictive practices, and the use of an open disclosure process.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)