Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Warramunda Village Hostel |
| Service address: | 5 Warramunda Drive KYABRAM VIC 3620 |
| Commission ID: | 3281 |
| Approved provider: | Warramunda Village Inc |
| Activity type: | Site Audit |
| Activity date: | 23 January 2023 to 25 January 2023 |
| Performance report date: | 20 March 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 Warramunda Village Hostel (**the service**) has been prepared by N Eastwood, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* the provider’s response to the assessment team’s report received on 20 February 2023 and 17 March 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **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

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 1

|  |  |  |
| --- | --- | --- |
| 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

Regarding the Requirements associated with Standard 1, consumers and representatives report they are treated with dignity and respect and their culture and diversity is valued and respected. The Assessment Team observed this in practise with staff consistently treating consumers with consideration and courtesy.

Consumers and representatives confirmed the service provides care and services that are culturally safe. Staff described ways in which they support consumers’ individual needs and encourage consumers to remain engaged with their heritage. Care planning documents describe consumers’ individual requirements, preferences related to the preferred gender of carers and prompts to assist with effective communication.

Consumers and representatives report the service supports consumers to exercise their choice and independence and make decisions about how care and services are delivered to meet their individual needs. Staff described how they support consumers to communicate decisions about preferred care and services as well as supporting them to maintain the relationships that are important to them. The Assessment Team observed respectful interactions between staff and representatives as well as accommodating requests for extended visiting hours at a family member request.

Consumers and representatives report being satisfied that the service supports consumers to do the activities they wanted to do, including where the activity involves an element of risk. Staff described how they manage risk with respect to individual consumers’ preferred activities. A review of care planning documents demonstrates evidence of a risk scale assessment which covers all questions relating to risk including dietary preferences and smoking.

Consumers and representatives confirm the information provided to them is current and easy to understand. Staff described how consumers and their representatives are provided with information about their care, services, and important issues. The Assessment Team observed documents and processes that enabled consumers to make informed choices such as the newsletter and calendar consumer’s rooms. Lifestyle and care staff were observed visiting consumers to inform them of activities such as pet therapy and exercise classes.

Consumers and representative report being confident their information is kept confidential and personal privacy is respected. Staff explained how they maintained a consumer’s privacy when providing care. Care staff were observed knocking on consumer doors before entering and closing doors behind them when attending to care. The Assessment Team observed treatment rooms and nurse’s stations to be locked and consumer medication folders were not left open on trolleys during medication rounds.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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 |
| 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

Regarding the Requirements associated with Standard 2, consumers and representatives indicate satisfaction with their involvement in the assessment and care planning processes including the identification and management of risks. Staff and management demonstrated knowledge of consumers’ risks and described strategies to ensure their safe and effective care. The Assessment Team observed individual documentation of a range of validated risk assessment tools to identify consumer risks.

A review of care planning documentation demonstrated completed risk assessments and preventative strategies. A review of care files also reflects documentation of individual goals, needs and preferences during the assessment and care planning process, as well as consideration of advance care plans. There was evidence of implementation Advance Care Directives, review in consultation with the nominated representative, and end of life planning consistent with consumer wishes.

Assessments and care plans demonstrate partnership with consumers and representatives in their initial development and then bimonthly. Staff and management described the involvement of other organisations such as the nutritionist, physiotherapist, geriatrician, the general practitioner, local hospital health team and dementia specialist. The Assessment Team reviewed care files which confirm ongoing discussions with representatives and consideration to individual consumer care.

Most consumers and representatives confirmed staff are responsive to changes in their care needs and preferences, however the Assessment Team noted a representative’s concerns regarding the services capacity to manage long term complex care needs. Staff were able to describe the monthly ‘resident of the day’ care review and bimonthly care plan review with the consumer and representatives. A review of documentation demonstrated reviews of care and individualised strategies following a change in consumers’ circumstances or following an incident such as a fall, unplanned weight loss, pressure injury, changed behaviour and medication error. The service has an ‘Assessment and planning - communication' policy that guides staff in the communication of care plan review outcomes with the consumer and/or representative in a way they can understand.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | 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. | Compliant |

Findings

The service was previously found non-compliant with Standard 3, Requirement 3(e) due to deficiencies in staff knowledge of the electronic care file system.

At the site audit the Assessment Team found the service has implemented effective actions to address the non-compliance.

A range of actions have been implemented including appointing ‘champions’ to guide the use of the electronic care file system, review of and implementation of strengthened handover processes, and the commencement of the regular consumer care reviews in consultation with the consumer and their representatives.

Regarding Requirements 3(a), (b), (c) and (d) most consumers and representatives are satisfied with the provision of care at the service. The service demonstrated care which aligns with best practice in the management of pain, skin integrity and wound management. Staff described how the assessment and management of pain is considered before a wound dressing change, when a consumer exhibits a changed behaviour, and following a fall. The Assessment Team noted that although pain chart monitoring is not always completed in line with the service’s policy, progress notes show consumer pain is identified and addressed.

The service demonstrated effective strategies in relation to management of high impact or high prevalence risks such as medications, falls, behaviour, urinary catheters, unplanned weight loss, pressure injuries, choking risk, and specialised care needs. Staff were able to describe and demonstrate personalised strategies on how to minimise frequency of risks for consumers. A review of documentation supported timely investigation and effectiveness of current strategies to ensure consumers’ high impact or high prevalence risks are evaluated.

Staff were able to describe the palliative care pathway and resources available to them to support consumers nearing the end of life. A review of care files demonstrated documentation containing information related to the individuals wishes and the care they would like to receive in line with their needs and preferences. Care planning documentation demonstrates how the service plans to deliver dignified palliative or comfort care to consumers in line with their needs and preferences.

Consumers and representatives reported satisfaction with identification and appropriate management of deterioration or changes in health conditions and function. Staff were able to describe the process for escalation where there are signs of deterioration. A review of care files demonstrated timely identification, assessment, monitoring, and management of consumers.

Regarding Requirement 3(3)(e) consumers and representatives confirm they are satisfied and confident with staff knowledge of each consumer’s assessed personal and clinical needs. Staff describe how they access and refer to consumers’ progress notes, clinical charts, care plans and handover sheet for accurate consumer information and changes in condition. The Assessment Team observed staff accessing the electronic system which contained information about each consumer’s health condition, needs, goals and preferences.

Regarding Requirement 3(3)(f) and (g) where referrals were required, consumers and representatives confirmed they are satisfied with their access and referrals to general practitioner, specialists and allied health professionals as needed. Staff described the referral process and provided examples of completed referrals to the speech pathologist and general practitioner.

The service has policies and procedures related to antimicrobial stewardship and infection control to minimise the risk of infection transmission at the service. Staff demonstrated knowledge of antimicrobial stewardship and were able to provide examples of how they support this in care delivery. The Assessment Team observed infection control practices related to the minimisation of COVID-19 transmission, such as the use of personal protective equipment and screening of staff and visitors in addition to a current outbreak management plan.

As a result of the service’s additional actions and with consideration to the available evidence, I am satisfied this standard is now compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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

Regarding the Requirements associated with Standard 4, consumers and representatives reported satisfaction with the services and supports which enhance consumer quality of life and optimise wellbeing. Staff outlined strategies employed to support consumer independence, which was supported by documentation and observations. A review of care files reflects evidence of a consumer making independent trips out of the service to visit family and into the local community.

Consumers confirmed their emotional, spiritual, and psychological well-being is supported and the service supports them to participate in the community, have relationships and do things of interest to them. Staff described how consumers are supported by spending time and engaging in meaningful activities or conversation. A review of care planning documentation reflects information related to consumers’ individual emotional, spiritual, and psychological needs. The care files further reflect information about significant relationships within and outside the service, consumers’ interests, and participation in activities at the service and within the local community. Lifestyle staff confirmed the activity program is planned to meet consumers’ interests and needs with the ability to adapt as required.

Consumers and representatives expressed satisfaction with the communication between the service and others who share responsibility for care. The Assessment Team observed a social worker visiting consumers after referral for attendance. staff were able to explain how they are updated regarding changes to consumer condition or needs. Documentation reviewed by the Assessment Team, including care plans and progress notes, demonstrated the safe and effective sharing of consumer information between staff as well as referrals to allied health professionals and community organisations

Consumers and representatives reported satisfaction with the variety and quality of meals at the service. Staff were knowledgeable about individual consumers’ preferences and dietary requirements. Staff were observed to be respectfully assisting and offering choices with meals during the Site Audit. Care planning documents reflect consumers’ dietary needs, dislikes, allergies, and preferences. The service demonstrated that a variety of meals are provided based on a six-monthly seasonal menu. There was evidence that changes to dietary requirements were communicated to kitchen staff in a timely manner with the chef confirming the process involving a nutritionist or speech pathologist and approved by the Registered Nurse.

Consumers and representatives were satisfied that the equipment in use at the service is safe, suitable, clean, and well maintained. Consumers and staff described the process for reporting an issue and reported items are repaired or replaced quickly when required.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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

Regarding the Requirements associated with Standard 5, consumers and representatives said the service is clean and well maintained, consumers described feeling at home and comfortable and encouraged to personalise their rooms. Consumers were observed moving around freely through the internal and external communal areas, the living environment is welcoming and easy to navigate. The Assessment Team observed the service environment, furniture, and equipment to be clean and well-maintained. Staff were able to describe their role in ensuring a safe environment such as, attending scheduled cleaning and preventative maintenance, reporting identified issues and attending to repairs promptly.

Consumer rooms and bathrooms, communal areas, and outdoor areas were noted to be clean and well maintained. Documentation of completed maintenance and cleaning demonstrated regular attendance to audits of the call bell system and sensor beams as well as prompt response to maintenance requests.

The Assessment Team noted some excess equipment and stained flooring which management confirmed is waiting replacement, along with some additional upgrades to the closed-circuit television system and the outdoor courtyard space.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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

Regarding the Requirements associated with Standard 6, consumers and representatives confirmed they are comfortable to raise concerns and provide feedback to the service. They felt that management had listened to their feedback and acted to address any concerns. Staff and management discussed their role in supporting consumers and their representatives to provide feedback including access to interpreter services, advocacy, and assistance with completion of feedback forms.

The Assessment Team observed posters and pamphlets informing about internal and external complaints processes, feedback forms and secure lodgement boxes accessible throughout the service. There was information available related to advocacy advocacy services, including ‘Older Persons Advocacy Network (OPAN)’, the Aged Care Quality and Safety Commission, and interpreter services on display throughout the service.

Most consumers and representatives were satisfied their complaints had been resolved, however the Assessment Team noted not all representatives were satisfied with the outcome of investigations. Management and staff were able to explain what open disclosure means to them and how they practise this when addressing consumer and representative feedback or when something goes wrong. The Assessment Team observed documentation showing open disclosure principles incorporated into the service’s complaints and incident management processes and the complaints register which showed that consumer and staff feedback is documented, investigated, and used to inform service improvement.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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

The service was previously found non-compliant with Standard 7, Requirement 3(a) and 3(c) due to identified deficits related to:

* severe workforce shortage during a reported outbreak, and
* the available skill mix of adequate staff to provide quality and safe care and services.

At the site audit, the Assessment Team found the service has implemented effective actions to address the non-compliance.

Regarding Requirement 7(3)(a) consumers provided positive feedback about staff responsiveness and the care they receive to meet their needs and preferences. Some representatives considered there was not enough staff, or adequately skilled staff to provide the care consumers require. Most staff confirmed they have enough staff on site, particularly with the introduction of an additional ‘float’ staff member. A review of rosters reflected a reduction in the use of agency staff and unfilled shifts. There were no records of concerns raised regarding call bell response times.

The Assessment Team reviewed the services plan for continuous improvement which addresses the previously identified deficits. The service has recruited senior clinical management, supporting clinical and administrative personnel, conducted a review of the staffing structure resulting in further recruitment of staff in vacant positions and designations including care, lifestyle, and hotel services.

There was evidence to support the service has implemented the planned actions to deliver improvements in the level of staffing and skill mix of rostered staff.

Requirement 7(3)(b) consumers and representatives described staff as kind and respectful and understand what is important to the consumers. The Assessment Team observed staff to be reassuring, kind and supportive in their interactions and communication with consumers. Some representatives were concerned that staff were rushed and unable to provide opportunities for activities and engagement for consumers. The Assessment Team observed staff across all designations were observed to interact with consumers in a respectful and unrushed manner and staff were able to discuss the consumer’s needs and preferences.

Regarding Requirement 7(3)(c) some consumer representatives provided missed feedback regarding the capacity to manage complex clinical care requirements, however the service provided evidence of consideration to the overall structure of staffing and availability of skilled and competent staff across shifts. The service has appointed a senior clinical management team to oversee the recruitment and onboarding of the workforce. Medication management training is to be delivered by clinical management and medication endorsed staff are required to demonstrate competency on an annual basis. All staff are required to be compliant with police checks and hold the relevant qualifications for their appointed role.

Management described the increase to clinical oversight, the revised management team structure, and the addition of 30 new staff members in the previous 6 months. The skill mix identified the presence of clinical oversight by the clinical care manager, a Registered Nurse across all shifts, in addition to team leaders in the residential units as well as care staff.

The service provided evidence of ongoing training support for staff to attend Infection Prevention Control (IPC) courses and allocation of clinical staff members to IPC lead positions. A review of training records reflects requirements for annual medication training and new staff member mandatory training modules.

The service has also reviewed and restructured the clinical and care workforce to ensure one medication endorsed staff member is rostered for each unit on day and afternoon shifts. A review of previous rosters by the Assessment Team, demonstrated a registered nurse rostered for each shift, and the clinical management team, who hold nursing qualifications, confirmed they are rostered for on-call shifts when required.

Requirement 7(3)(d) and (e) while some staff members confirmed they had not yet completed a formal appraisal since commencement the service provided evidence of the newly implemented process which was further supported by notices on display in staff areas. Staff explained they are aware of the formal appraisal process and management confirmed the responsible parties to complete the appraisals within the designated time frame.

As a result of the service’s additional actions and with consideration to the available evidence, I am satisfied this standard is now compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

The service was previously found non-compliant with Standard 8, Requirement 3(c) and 3(d), a as the service was unable to demonstrate:

* adequate governance to support sufficiently skilled and qualified staff, a stable management structure, and adequately supported workforce to deliver safe and quality care and services, and
* effective risk management systems and practices to care for complex care consumers due to staff shortages and instability in management structure.

At the site audit, the Assessment Team found the service has implemented effective actions to address the non-compliance.

Regarding Requirements 8(3)(a) and 8(3)(b) consumers and representatives provided mixed feedback on engagement in the development, delivery and evaluation of care and services. Some consumers described the service as well run and staff are providing care and services they need. Some representatives indicated there was not an opportunity to engage with management to improving care and services. Staff explained they ensured consumers were kept up to date with the scheduled activities and encouraged the consumers to attend resident and relative meetings. Management confirmed information was provided in the monthly newsletter, emailed updates to representatives, staff and other stakeholders via ‘Whispa’ the messaging platform used by the service.

The director of clinical services reports to the Clinical governance committee and the Board each month on the clinical outcomes including the number of incidents, the progress of planned improvements and staff performance. The service has undergone a Board restructure following review of the organisational governance structure. The Board now includes members with qualifications in health, government services and community planning.

Improvements planned by the service to improve workforce governance, information management, and risk management have flowed on to ensure the governing body is accountable for the delivery of quality and safe care and services. The Board has access to the electronic system for clinical risk indicators, risk matrix, reports, and other documents relating to human resources, clinical incidents, and the feedback and complaints register. They are also actively involved in review of policies and procedures and recruitment.

Regarding Requirement 8(3)(c) the Assessment Team reviewed a plan of action to address previously identified deficiencies. Improvement in information sharing between staff, assessment and care planning documentation and the implementation of regular monthly care reviews of consumers were identified.

The service implemented protected handover times and daily huddles, resources were made available for agency staff to ensure information related to the services process and emergency procedures was available. A comprehensive audit was undertaken of the electronic care file system with all consumers details updated. Management implemented a specialised risk register to identify changes and increased risk which is discussed and updated weekly by the clinical management team. The Assessment Team reviewed the plan for continuous improvement noting the service is not recording actions as a result of feedback, complaints and suggestions or the plan for environmental updates.

The service demonstrated financial governance systems, with management describing approval processes for expenditure as well as examples of recent purchases to improve consumer care and service delivery. The service underwent a comprehensive review of the workforce governance and has implemented strategies to ensure the service has sufficient staff that are supported in their roles by the management team, as well as providing mandatory training and education opportunities to ensure staff are equipped to provide quality care and services.

Regulatory compliance updates are obtained though subscription to Commonwealth and State government aged care and health newsletters, updates, and the sector’s leading bodies. Changes are reported to the Board through the electronic risk tracker system. The electronic policy and governance platform and the electronic document system are supported through ongoing updates to regulatory compliance. A summary of complaints and feedback is reported to the Board, including external complaints and the actions taken to resolve the concerns or issues.

Regarding Requirement 8(3)(d) the Assessment Team reviewed a plan of action to address previously identified deficiencies. A review of the risk management systems with a focus on ensuring effective framework to support staff to recognise and support risk and timely reporting of clinical incidents was identified.

The service has strengthened the clinical oversight and management structure within the service. The service’s electronic care file system has been updated to ensure alerts are sent to the appropriate clinical manager to ensure incidents are investigated, the consumers receive timely referral and review and outcomes evaluated for ongoing improvement. There was evidence of review of post fall audits which reflected inconsistency in documentation of clinical observations, further education has been planned related to use of the post fall flow chart. Staff were able to demonstrate knowledge on reporting incidents, the processes they have been taught in relation to fall management, skin integrity issues, and change in behaviour of consumers.

The organisation structure has been reviewed and now includes a team leader appointed to each of the residential units. The team leaders are being supported to provide the staff in their teams with direction, support, and responsibilities of recognising and responding to risks, to follow the updated reporting process in relation to clinical incidents, SIRS reporting and supporting residents to live the best life they can.

Staff demonstrated knowledge on reporting incidents, the processes they have been taught in relation to falls management, skin integrity issues, and change in behaviour of consumers. The Assessment Team reviewed documentation related to clinical incidents, audit results and Serious Incident Reporting which demonstrated outcomes to specific events such as additional training, staff counselling and competency review.

The service now demonstrates an effective organisation wide governance system, as well as effective risk management systems and practices. The service demonstrated improvement in workforce governance, implementing several strategies to ensure there are sufficiently trained and supported staff. There is ongoing evidence of recruitment, training, and development in addition to evaluation and assessment of risk, current trends, and incidents. As a result, and with consideration to the available evidence Requirement 8(3)(c) and 8(3)(d) are now compliant.

Regarding Requirement 8(3)(e) the Assessment Team found the service did not demonstrate an adequate clinical governance framework to support the minimisation of restraint use. The Assessment Team reviewed a number of the service’s clinical policies, clinical registers, and consumer care files, as well as conducting interviews with management and staff regarding their understanding of antimicrobial stewardship, restrictive practice, and open disclosure.

With consideration to the available information, Approved Providers response and updated Plan for Continuous Improvement, I have come to a different view.

The service’s clinical governance framework has undergone review by an external governance consultant. The review identified recommendations to ensure all clinical governance systems, policies and procedures are robust and support management and staff to provide best practice clinical care. The Assessment Team reviewed documentation related to restrictive practice and found the service has commenced work on appropriate oversight. However, the information available related to the use of psychotropic medication was limited to a list of prescribed medication. The information did not contain a summary of information reflecting a comprehensive understanding of each consumer receiving psychotropic medication or reference to the required strategies to utilise restrictive practice as a last resort.

The Approved Provider responded to the concerns identified by the Assessment Team, providing evidence of a transition to electronic charting, and recording of psychotropic medications. The service has implemented restrictive practices as a standing agenda item which is supported by meeting minutes which reflect recent discussions by clinical staff and the requirements for behaviour support plans. The service has also implemented three monthly care plan and assessment reviews, these include a review of consent documentation where a psychotropic medication is being used, as well as consultation with treating medical practitioners and local pharmacies.

The Approved Provider response indicates the transition to an electronic medication administration system for ‘real time reporting’ which reflects the frequency, indication and initial prescription date of psychotropic medication. In isolation, the electronic reporting function does not include the required detail for appropriate consideration of all aspects of consumer care at the time of administration. To address this, the Approved Provider submitted further evidence to support the introduction of an effective self-assessment system for administration of psychotropic medication. To enable assessment of all considerations at the time of administering a psychotropic medication the service now has appropriate information available which is able to reference consent, behaviour support planning, adequate monitoring of use in prescribed circumstances and evaluation to ensure restrictive practices are minimised.

The service has enrolled in the National Antimicrobial Prescribing Survey which supports improvements in staff understanding of the use of antimicrobials with an aim to promote their appropriate use. Staff were able to describe their understanding of open disclosure and gave examples of incidents or adverse events that had occurred when open disclosure would be used. Incident reports reviewed by the Assessment Team reflected the provision of information using open disclosure principles.

With consideration to the Approved Providers response, actions, improvements, and available information, I am satisfied the service has adequately addressed the identified concerns related to minimising the use of restrictive practices and find the service compliant with Requirement 8(3)(e).

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