Performance

Report

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| Name of service: | Performance report date: |
| Waverley Valley Aged Care | 28 June 2022 |
| Commission ID: | Activity type: |
| 3564 | Site audit |
| Approved provider: | Activity date: |
| Glenvoir Holdings Pty Ltd | 3 May 2022 to 6 May 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 Waverley Valley Aged Care (**the service**) has been considered by S Byers, 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, dated 3 May 2022 to 6 May 2022; the site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 10 June 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 2(3)(a): Implement effective processes to ensure assessment and care planning, including consideration for risk, informs delivery of safe and effective care.
* Requirement 2(3)(d): Implement effective processes to ensure the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan.
* Requirement 2(3)(e): Implement effective processes to ensure care planning documents are reviewed when circumstances change or when incidents occur.
* Requirement 3(3)(a): Ensure planned care that is tailored to each consumer’s needs is consistently delivered and best practice clinical principles applied, particularly in relation to skin integrity, wounds and pain management.
* Requirement 4(3)(b): Implement processes to ensure services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.
* Requirement 6(3)(c): Ensure all complaints are recorded and actioned appropriately in a timely manner and the complainant’s level of satisfaction with the outcome is ascertained prior to closure.
* Requirement 7(3)(a): Ensure staffing is planned to enable the management and delivery of safe and quality care and services to mitigate adverse impact to consumers.
* Requirement 7(3)(e): Implement an effective performance appraisal system to ensure the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

# 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

This Quality Standard is Compliant as six of the six specific Requirements have been assessed as Compliant.

Consumers were satisfied they feel valued as they are treated with dignity and respect. Consumers and representatives confirmed that staff deliver care and services that is culturally safe.

Consumers and representatives confirmed that staff know what is important to them, that they are encouraged to do things for themselves and timely information is provided on planned lifestyle activities and other services.

Consumers confirmed that they have choice in their daily activities and are supported in maintaining connections inside and outside the service. Consumers confirmed that they are supported to take risks that enables them to live the best life they can.

Consumers described how staff respect their personal privacy by entering their rooms after gaining permission.

Staff demonstrated they are familiar with the individual needs and preferences of the consumers. Staff described how they deliver culturally safe care and support consumers to exercise choice and independence. Staff provided examples where consumers are supported to take risks, and the interventions in place to manage the risks.

Care documentation reflected individual consumers' identity, cultural needs and preferences. Consumer care plans identified consumers can safely engage in activities of choice and are supported to take risks.

The service has a suite of policies relating to consumer dignity and choice including the delivery of culturally safe care to guide staff practice.

Staff interaction with consumers was observed to be respectful and kind. Staff were observed to be respecting consumers’ private space and gaining permission prior to entering rooms. Where verbal permission was not possible, staff were observed to be introducing themselves and the reason for their visit to consumer as they entered the room.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-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. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-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. | Non-compliant |

## Findings

This Quality Standard is Non-compliant as three of the five specific Requirements have been assessed as Non-compliant.

In relation to Requirement 2(3)(a), the Assessment Team found that assessment processes at the service did not adequately identify risks in various clinical areas including falls and pressure injuries. Assessment information did not accurately inform care plans. Where a risk to a consumer’s health and well-being was identified, appropriate care plans were not always developed with strategies to manage and/or minimise the risk. The Assessment Team also found the service did not use validated risk assessment tools to re-assess consumers risk.

The Assessment Team provided an example of a consumer who entered the service for respite care who did not have an initial assessment and care plan or interim care plan developed until three weeks after entry. While it was identified the consumer experienced pain, falls and had pressure injuries, care planning documentation did not reflect strategies to manage these risks.

The Assessment Team provided information for two consumers where assessment and care planning documentation did not consider risks and appropriate strategies associated with falls, swallowing difficulties, weight loss, skin integrity and pressure injuries. Interventions and strategies to manage risks recommended by other health professionals including physiotherapists and speech pathologists were not identified in the consumers care documentation.

The Approved Provider disputes some of the Assessment Team’s findings. The Approved Provider submitted a response that included clarifying and conflicting information to the site audit report and additional documentation including initial clinical assessments, progress notes, care planning and assessment documentation, charting and Falls Risk Assessment Tools (FRAT’s).

The Approved Provider submits the failure to complete the consumer’s initial care plan was due to staff oversight and this is not the services normal practice. The Approved Provider refutes the Assessment Team’s findings that validated risk assessment tools were not used to re-assess risk asserting the assessment tools in the clinical documentation system are all validated tools.

While I note that some of the documentation submitted by the Approved Provider addresses some of the Assessment Team’s findings, I note that several of the documents were updated or dated after the site audit was completed. I acknowledge the action taken by the service since the audit to address the deficits, however, these steps have not been fully implemented and evaluated.

In making my decision I have considered the site audit report and the Approved Provider’s response. Based on the evidence available to me I consider at the time of the site audit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with Requirement 2(3)(a)

In relation to Requirement 2(3)(d), the Assessment Team found the service did not demonstrate outcomes of assessment and planning are effectively communicated to consumers and/or representatives and documented in care plans that are readily available to the consumer. Representatives provided feedback they had not been communicated with about the outcomes of consumer care plan reviews. The Assessment Team identified deficits in care plans that did not reflect that outcomes of the most up-to-date assessments and reviews of consumer needs, goals or preferences had been appropriately documented. For example, care documentation did not reflect the outcome and communication of a consumer’s pain evaluation.

The Approved Provider disputes the Assessment Team’s findings. The Approved Provider submitted a response that included clarifying information to the site audit report and additional documentation including screen shots of their clinical documentation system.

While I note that some of the documentation submitted by the Approved Provider goes some way in addressing some of the Assessment Team’s findings, I note that several of the documents were updated or dated after the site audit was completed. I acknowledge the action taken by the service since the audit to address the deficits, however these steps have not been fully implemented and evaluated.

In making my decision I have considered the site audit report and the Approved Provider’s response. I place weight on the Assessment Team’s findings and the wording of this requirement, specifically, “documented in a care and services plan …” Based on the evidence available to me I consider at the time of the site audit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with Requirement 2(3)(d).

In relation to Requirement 2(3)(e), while the Assessment Team found the service had systems and processes in place to review consumer care and services on a scheduled basis and when changes occur, the service did not demonstrate care and services were reviewed for effectiveness when an incident or a change in consumer’s circumstances occurred.

Care plans did not reflect changes in the care of consumers following reviews by staff and other health professionals including Dementia Support Australia. Care documentation did not reflect recommended strategies to support the change in consumer care relating to pain, skin integrity, falls, dietary needs and preferences. Care documentation did not reflect a review of new experienced pain for one consumer. While progress notes recorded a consumer’s fall, there was no recorded incident report to demonstrate the fall and contributing factors had been investigated.

The Approved Provider disputes some of the Assessment Team findings. The Approved Provider submitted a response that included clarifying and conflicting information to the site audit report and additional documentation including consumer care plan and assessment documentation and screen shots of the services clinical documentation system

While I note that some of the documentation submitted by the Approved Provider addresses some of the Assessment Team’s findings, I note that several of the documents were updated or dated after the site audit was completed. I acknowledge the action taken by the service since the audit to address the deficits, however these steps have not been fully implemented and evaluated.

In making my decision I have considered the site audit report and the Approved Provider’s response. Based on the evidence available to me I consider at the time of the site audit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with Requirement 2(3)(e).

I am satisfied the remaining two requirements of Quality Standard 2 are Compliant. Consumers and representatives provided feedback they were partners in the ongoing assessment and planning of consumers’ care and services.

The service demonstrated assessment and planning identified and addressed the consumer’s current needs, goals and preferences including advance care planning and end of life planning. The service demonstrated consumers and representatives were involved in assessment and planning, as well as other health professionals, such as medical officers and allied health practitioners as required.

# 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. | 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

This Quality Standard is Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant.

In relation to Requirement 3(3)(a), while the Assessment Team found consumers subject to chemical restrictive practices are assessed, monitored and reviewed according to regulatory requirements, the service did not demonstrate consistent best practice in relation to the management of consumer’s pain, skin integrity and wounds including pressure injuries. Representatives provided negative feedback that staff did not provide consistent pressure area care and consumers showed signs of discomfort when sitting in the same position. Consumers confirmed experiencing ongoing pain.

Staff described how a shortage in staffing impacts on their ability to attend to the consumers pressure area care in line with their repositioning schedule. Staff also indicated staffing shortages impacted on wound care. Staff were unable to describe the recommended strategies from external health professionals in place to manage skin integrity or pain management for one of the named consumers in the site audit report.

The Assessment Team identified several deficits in documentation that demonstrated care was not tailored to the consumers individual needs and did not guide staff practice. Relevant recommended strategies and care directives were identified to be inconsistent across care documentation. For example, care planning documents did not reflect recommended strategies from other health professionals including physiotherapists and Dementia Support Australia.

I have also considered deficits identified in consumer care documentation relating to the consideration of risk, reassessment and review when circumstances change under Requirements 2(3)(a) and 2(3)(e).

While ongoing input from a wound consultant and general practitioner was evidenced, care documentation demonstrated deficits in consistency of the monitoring, management and review of a consumer’s wounds. The consumer’s wounds were not consistently dressed in line with care directives and as a result were not resolving. Input from allied health professionals in relation to pressure-relieving devices were not considered, for a consumer who is a very high risk of developing pressure injuries.

The Assessment Team observed strategies were not being followed in line with consumer’s care directives in relation to skin care and pressure injury management. For example, a consumer with a care directive to be repositioned every four hours was observed seated in the same position for more than a four-hour period each day of the site audit.

The Approved Provider provided a response that included clarifying information to the site audit report and additional documentation including care plans and assessments, progress notes, charting and allied health assessments.

While I note that some of the documentation submitted by the Approved Provider addresses some of the Assessment Team’s findings, I note that several of the documents were updated or dated after the site audit was completed. I acknowledge the action taken by the service since the audit to address the deficits, these steps have not been fully implemented and evaluated.

In making my decision I have considered the site audit report and the Approved Provider’s response. While I acknowledge the complex needs of the consumers, I place weight on the Assessment Team’s evidence including observations and consumer, representative and staff feedback. Based on the evidence available to me I consider at the time of the site audit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with Requirement 3(3)(a)

I am satisfied the remaining six requirements of Quality Standard 3 are Compliant. Consumers and representatives were satisfied with the management of consumer’s risks and confirmed support from multidisciplinary teams. Representatives were satisfied with the advanced care and end of life planning process for consumers.

While, the service did not demonstrate effective assessment and care planning to identify, prevent or minimise consumers’ key risks as considered in Requirement 2(3)(a), the reviewed care files of consumers at risk of high impact or high prevalence risks demonstrated consumers’ risks are generally managed with input from other health care professionals as appropriate. Staff demonstrated they are aware of the risks associated with individual consumers’ care including falls, weight loss and specialised nursing care.

Staff described the palliative care pathway and the resources available to them to support consumers nearing their end of life. Staff demonstrated how they identify and monitor deterioration and the actions taken in response to changes in a consumer’s health needs.

Care documentation reflected palliative care planning is individualised and tailored to the consumer’s wishes. Care planning documentation reflected the identification of and response to, consumer deterioration or changes with input from medical practitioners and other health professionals.

Referral processes were in place and appropriate and timely referrals to external specialists, general practitioners and allied health are documented. Information is effectively documented and communicated.

The service demonstrated it has an infection control policy in place to guide staff practice. While the Assessment Team identified deficits with the services COVID-19 outbreak management plan I note that management efficiently rectified these deficits during the site audit. Standard and transmission-based precautions have been implemented to support the service to prevent and control infection. Staff were observed following Personal Protective Equipment guidelines. Staff demonstrated understanding and practical application of antibiotic stewardship and minimising antibiotic use.

# Standard 4

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| Services and supports for daily living | | Non-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. | Non-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

This Quality Standard is Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant.

In relation to Requirement 4(3)(b), the Assessment Team found the service did not demonstrate that each consumer’s emotional, spiritual and psychological well-being is supported*.*

The Assessment Team found that one consumer was not receiving effective emotional support after a change in circumstances, however, I note the consumer provided feedback that they feel at home at the service and it their choice to refuse to participate in activities and their preference is to stay in their room. This was supported by representative and staff feedback. Staff demonstrated knowledge of the consumers individual goals and preferences, including reading and regular visits with family.

While the Assessment Team identified deficits in the consumer’s lifestyle documentation, the Approved Provider submitted evidence that demonstrated the consumers change of circumstances had been recorded, lifestyle care plan reviewed and strategies including one on one time are in place.

With regard to the second named consumer in the site audit report, representatives provided negative feedback citing deterioration in the consumer since being at the service. Representatives raised concerns about how the consumer is often sitting alone in their room when they visit. This aligned with Assessment Team observations during the site audit. Lifestyle care plans did not reflect the consumer’s cognitive and physical decline and appropriate strategies to support the consumer in line with their documented interests, including one on one support.

The Approved Provider submits the consumer’s decline had been noted on care plans and several services have been put in place to support the consumer including one on one support and outings into the community. A checklist has also been developed to ensure all consumers who need one on one support receives that service.

I have reviewed all of the information provided. I have considered and place weight on the Assessment Team’s evidence and the wording of this requirement, specifically, “services and supports for daily living promote each consumer’s …” At the time of the site audit, the Provider did not demonstrate compliance with this Requirement. It is on this basis, I find the service Non-complaint with Requirement 4(3)(b).

I am satisfied the remaining six requirements of Quality Standard 4 are Compliant. Consumers provided feedback they felt safe and comfortable at the service and consider it their home. Consumers were mostly satisfied with the quality, quantity and variety of food.

The service provides a diverse lifestyle program for consumers that is tailored to meet their interests and encourages socialisation between consumers and staff. A weekly activity program is circulated to consumers which includes two bus outings per week. Staff demonstrated they know consumers well, describing how they provide care to support consumer independence, quality of life and overall well-being.

While deficits were identified in some lifestyle documents, overall the service demonstrated it has processes in place for effectively communicating consumers’ needs and preferences within and external to the service. Consumer care documentation demonstrated appropriate and timely referrals where required. Care plans reflected the dietary needs and preferences identified through consultation with the consumer and/or their representatives.

The service utilises a range of equipment and resources to support consumers in lifestyle activities. The equipment provided is safe, suitable and well maintained.

The Assessment Team observed consumers actively participating in group activities including tenpin bowling and exercise classes. Lifestyle staff were observed encouraging consumers who were responding positively.

**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

This Quality Standard is Compliant as three of three specific Requirements are assessed as Compliant.

Consumers stated that they like living at the service because it is safe, comfortable, referring to the service as their home. Consumers said that the furniture, fittings and equipment at the service are clean and well maintained. Consumers and their representatives were satisfied with the cleanliness and maintenance of the service environment and confirmed they could move freely indoors and outdoors. Staff are required to assist those with mobility issues to access the secured garden.

Staff understood how to report items requiring maintenance and the review of documentation identified reactive maintenance was attended to in a timely manner and preventative maintenance was undertaken as scheduled. Cleaning staff explained the cleaning processes and documentation demonstrated that all rooms were cleaned daily.

The service provides a safe and comfortable environment with several furnished communal spaces. The service was observed to be clean, spacious and well-lit. There is signage identifying the different areas of the service, and the service has two secured high dependency units, one of which is designed to resemble a family home.

Consumers were observed socialising in the larger communal areas and the secured garden, in the company of staff. Consumer rooms were observed to be personalised. Furniture and fittings were in good order and suitable for consumers. Consumers were observed using clean, well-maintained and appropriate equipment including walkers, wheelchairs, and comfort chairs.

**Standard 6**

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| Feedback and complaints | | Non-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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

## Findings

This Quality Standard is Non-compliant as one of the four specific Requirements have been assessed as Non-compliant.

In relation to Requirement 6(3)(c) the Assessment Team received negative feedback from consumers and representatives who were dissatisfied with the actions taken by the service in response to complaints or concerns raised. Complaints documentation reviewed was not up-to-date and incomplete.

The Approved Provider submitted a response that included clarifying information to the site audit report. The Approved Provider submits the organisation is reviewing the feedback and complaints process to ensure all complaints and feedback are recorded and actioned in a timely manner.

I have reviewed all of the information provided. Based on the evidence available to me, I find the service is Non-compliant with 6(3)(c).

I am satisfied the remaining three requirements of Quality Standard 6 are Compliant. Consumers and representatives interviewed felt they could make complaints and felt safe to do so. Representatives were aware of external complaints organisations and advocates that they could access.

Staff demonstrated an understanding of the service’s complaints handling process and open disclosure. Staff provided examples of how they assist consumers to make complaints.

The service demonstrated it provides several avenues for consumers and representatives to provide feedback and complaints. For example, feedback and complaints forms and residents’ meetings. Information obtained from consumers is added to the service’s continuous improvement register for action to improve quality care and services.

The Assessment Team observed feedback forms and boxes at the entrance of the service. There were also references to external organisations that advocate for consumers on noticeboards.

**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. | Non-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

This Quality Standard is Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

In relation to Requirement 7(3)(a) the Assessment Team received negative feedback from consumers, representatives and staff regarding the sufficiency of staff, particularly in relation to the memory support unit. Deficits in the safety and quality of care delivered by the service were identified by the Assessment Team, and several representatives described attending the service most days to ensure care is delivered to the consumers. For example, nutrition and hydration, toileting and hygiene. Both representatives and staff said there is not enough staff to ensure consistent pressure area care and repositioning for consumers. A roster review identified a number of unfilled shifts. During the site audit the Assessment Team observed only one staff member present in the memory support unit and on several occasions no staff supervising the dining area where a number of consumers required staff assistance with meals.

The Approved Provider submitted a response that included clarifying information to the site audit report and additional documentation including a master roster. The Approved Provider concedes that during the site audit unplanned sick leave left shifts unfilled and while management attempted to replace the shifts through several avenues, the vacant shifts were unable to be filled. The Approved Provider is actively taking steps to recruit more staff; however, recruitment has been somewhat impacted by the COVID-19 pandemic.

I have reviewed all of the information provided. I have placed weight on the Assessment Teams observations and consumer, representative and staff feedback at the time of the site audit. I consider at the time of the site audit the Approved Provider did not demonstrate compliance with the Requirement. On the balance of evidence available to me, I find the service is Non-compliant with Requirement 7(3)(a).

In relation to Requirement 7(3)(e), none of the staff the Assessment Team interviewed had been involved in a performance review and could not recall the last time they had a performance discussion with management. Documentation reviewed confirmed performance reviews for staff interviewed had not been conducted since 2018. Management confirmed performance appraisals had not been completed.

The Approved Provider submitted it intends to complete staff performance reviews by end of August 2022. It is planning on implementing a new staff appraisal system.

I have reviewed all of the information provided. Based on the evidence available to me, I find the service is Non-compliant with 7(3)(e).

I am satisfied the remaining three requirements of Quality Standard 7 are Compliant. Consumers and Representatives considered care staff are capable, kind and caring. The service demonstrated it has policies and procedures relating to recruitment, induction, performance monitoring and training of staff. All staff within the service complete mandatory training that directly links to their position description. Review of training documentation demonstrated most staff have completed mandatory training. There are systems in place to ensure staff are competent and have the qualifications and knowledge to perform their roles effectively. The organisation has systems in place to measure interactions between staff and consumers through observations and consumer feedback.

The Assessment Team observed staff interactions with consumers to be kind and caring.

**Standard 8**

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| Organisational governance | | 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. | 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

This Quality Standard is Compliant as five of the five specific Requirements have been assessed as Compliant.

All consumers and representatives sampled considered the service to be well run and that they could partner in improving the delivery of care and services. Management provided examples of how consumers and representatives are engaged to provide feedback including meetings and feedback forms.

The organisation has a suite of systems, processes and materials to promote a culture that is safe, inclusive and quality care and service and is accountable for their delivery. Staff described how management are visible and accessible in the service. Consumers and representatives provided feedback that they feel safe at the service.

The organisation has effective governance systems in relation to continuous improvement, financial and workforce governance and regulatory compliance. Quality audits are conducted monthly where improvements are required they are entered onto the continuous improvement register to be actioned.

While the Assessment Team identified some deficits in relation to staff application of information systems and workforce planning and performance, I do not have sufficient evidence to support the organisation does not have effective governance.

The organisation provided a documented risk management framework supported by policies and procedures documented to manage risk. The organisation demonstrated it has an effective incident management system in place. Incident documentation demonstrated incidents are investigated and outcomes recorded. Risks are reported, escalated, and reviewed by management. The organisation has a compulsory reporting procedure. Staff demonstrated understanding of mandatory reporting and confirmed completing training on the topic.

The organisation demonstrated it has a clinical governance framework which includes antimicrobial stewardship, minimising the use of restraint and an open disclosure policy. Staff were asked about whether these policies had been discussed with them and what it meant for them in a practical way. Staff had been educated about the policies and were able to provide examples of the relevance to their work. staff demonstrated understanding and knowledge in effectively identifying and managing restrictive practices.

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