Performance

Report

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| Name: | Abberfield Aged Care Facility |
| Commission ID: | 4002 |
| Address: | 376-380 Bluff Road, SANDRINGHAM, Victoria, 3191 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 24 September 2024 |
| Performance report date: | 25 October 2024 |
| Service included in this assessment: | Provider: 1434 Sandra Pty Ltd  Service: 2605 Abberfield Aged Care Facility |

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 Abberfield Aged Care Facility (**the service**) has been prepared by N Chahal, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 14 October 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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.

**Standard 3**

* Requirement 3(3)(a),

ensure effective systems are in place to identify and manage chemical restrictive practices in line with best practice and legislative requirements. Including consistent documentation of informed consent and individualised behaviour support plans.

**Standard 4**

* Requirement 4(3)(f)

ensure meals provided to consumers are of suitable quality and quantity and improve the dining experience.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |

Findings

I have assessed this Quality Standard as Not-compliant as I am satisfied Requirement 3(3)(a) is Non-compliant:

The Assessment Team identified that the service was not effectively identifying and managing chemical restrictive practices. Consequently, informed consent for chemical restraint was inconsistent, and behaviour support plans were not individualised or updated following changes in behaviour.

A review of the psychotropic register evidenced that the service had not identified over 40 consumers who were subject to chemical restraint, and informed consent was not consistently obtained according to the service’s policy and legislative requirements. Additionally, a review of care documentation for 14 consumers showed that behaviour support plans were mostly generalised, with few individualised strategies listed.

The Assessment Team also identified two consumers who were receiving psychotropic medication with inconsistent identification of chemical restraint and documentation of informed consent. One consumer was receiving medication without a specific indication, while the other was receiving medication to manage changed behaviours. Management acknowledged that the service’s restrictive practice register, in particular for consumers subject to chemical restraint, is an identified area for improvement. The Assessment Team noted that clinical and care staff were knowledgeable about the care needs and changed behaviours of consumers.

The Approved Provider has submitted a Plan for Continuous Improvement (PCI) in response to the deficits identified by the Assessment Team. The PCI included detailed actions with planned completion by November 2024. The actions implemented and currently in progress include, establishing a working committee with medical practitioners and clinical staff, distributing restrictive practice guidelines to staff, referrals to the Adult Mental Health Team for consumer subject to chemical restrictive practice, review of consumers behaviour support plans and reidentification of informed consent for all consumers subject to chemical restraint.

I am satisfied the Approved Provider demonstrated safe and effective care is delivered in relation to management of environmental and mechanical restrictive practice, skin integrity and wounds, pain management and specialised care.

In making my decision I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the assessment contact, these actions have not been fully implemented, evaluated, and embedded. I am not satisfied the Approved Provider has demonstrated it has effective systems in place to ensure effective identification and management of chemical restrictive practices in line with best practice and legislative requirements. I find Requirement 3(3)(a) is Not-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |

Findings

I have assessed this Quality Standard as Not-compliant as I am satisfied Requirement 4(3)(f) is Non-compliant:

The Assessment Team received mixed feedback from consumers regarding the quality and quantity of food provided. Six of the 7 sampled consumers could not recall choosing menu items. One consumer described the food as ‘bland’, and another said it ‘looked like a hospital meal’ and noted that it was cold. The Assessment Team assessed the consumer’s meal with consent and found it to be cold. This feedback was acknowledged by staff, and the meal was reheated.

Management explained that the menu is provided to consumers and representatives upon admission or when a new menu is introduced, with selected meals offered on a 4-week rotation. Kitchen management stated that consumer feedback is received through written notes and emails from representatives, which are entered into the service’s feedback register. Additionally, no recent consumer feedback has been received from consumer meetings due to low attendance. Management acknowledged that complaints about food are the most common type of feedback. The service’s PCI evidenced a range of actions in progress to improve food quality and evaluate consumer feedback and surveys.

The Assessment Team’s observation of dining rooms and a meal service identified that daily menus are not displayed in dining rooms, and meals are served on trays with the main meal covered by a plastic cloche. Condiments were not on tables, and second servings were not offered.

The Approved Provider has submitted a PCI in response to the deficits identified by the Assessment Team. The PCI included detailed actions with planned completion by November 2024 and a review by January 2025. The actions implemented and currently in progress include, but are not limited to, placing menu display stands in dining areas, issuing a new care directive to staff to ensure that meals in dining areas are not distributed on trays and that heat-retaining cloches are removed, reintroducing placemats and tablecloths, and introducing condiment trays. Additionally, in the long term, the organisation is investigating the safe use of bain-maries in dining areas and the possibility of serving hot breakfasts ‘buffet style’ to consumers.

In making my decision, I have considered the Assessment Team’s report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the assessment contact, these actions have not been fully implemented, evaluated, and embedded. I am not satisfied that the Approved Provider is ensuring meals provided to consumers are of suitable quality and quantity. I find Requirement 4(3)(f) is Not-compliant.

# Standard 7

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| 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 |

Findings

Consumers and representatives confirmed that the service has sufficient staff to ensure the provision of safe and quality care. Clinical and care staff provided positive feedback on the staffing levels at the service and confirmed having enough time to provide quality care to consumers. Management described how they regularly review the roster to ensure clinical staff have the qualifications, skills, and experience to provide appropriate care and manage teams effectively. Planned and unplanned leave is covered using part-time and casual staff. The service demonstrated ongoing recruitment and provided examples of newly appointed staff and new roles in both clinical and non-clinical areas. A review of the master roster and shift allocation demonstrated a planned workforce, with registered nurses working alongside personal care assistants in each area during the day. The service has one registered nurse overnight to provide clinical oversight to all consumers, with personal care assistants in each area.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 7(3)(a).

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

The service demonstrated that it has effective organisation-wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. Management described systems and processes in place to monitor and review routine reporting and analysis of data related to consumer experience, ensuring the right care is provided in line with the Quality Standards.

Management and staff stated that they can access the information they need. Policies, procedures, consumer information, changes to legislation, and regulatory requirements are accessed via an electronic information management system and shared drive. The service identifies opportunities for continuous improvement from several sources, including incidents, consumer feedback, surveys, consumer meetings, internal audit results, and clinical indicator data. The Assessment Team observed the service’s PCI, where the progress of implemented improvement activities is documented, and outcomes are evaluated for effectiveness.

The service has policies, procedures, and practices to ensure the workforce is managed in accordance with regulatory requirements. Staff responsibilities and accountabilities are established, and the service has relevant training systems in place. Staff confirmed they have been informed of the mandatory care minutes and 24/7 RN responsibilities. The service has a registered nurse rostered 24 hours a day, seven days a week. The service is currently exceeding its total care minutes target and meeting its registered nurse minutes.

There is a feedback and complaints management system, and a review of the complaints register evidenced that the organisation’s leadership and governance team maintain oversight of the feedback and complaints. There is evidence of effective financial governance systems in place. Management described that the service has procured a new electronic information management system to capture service data into one system, which will promote the accuracy of information. This includes continuous improvement, incidents, feedback and complaints, clinical indicators, and policies and procedures.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 8(3)(c).

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