Performance

Report

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| Name of service: | Adventist Nursing Home |
| Service address: | 56 Elsom Road KINGS LANGLEY NSW 2147 |
| Commission ID: | 2562 |
| Approved provider: | Seventh-day Adventist Aged Care (Greater Sydney) Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 June 2023 to 9 June 2023 |
| Performance report date: | 8 July 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 Adventist Nursing Home (**the service**) has been prepared by G Cherry, 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 - Site; the Assessment Contact - 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 3 July 2023 which includes a Plan for Continuous Improvement (PCI) dated 30 June 2023
* Performance Report dated 15 December 2022

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **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.

* Requirement 3(3)(b) – implement an effective system to ensure appropriate management of high impact/prevalence risks particularly relating to pressure injury, diabetes, and behavioural management result in consistently meeting consumer’s care needs
* Requirement 3(3)(d) - implement an effective system to ensure deterioration or change in consumers’ health, cognitive/physical function, capacity, or condition is recognised and responded to in a timely manner to ensure consumer’s needs are consistently met.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |

Findings

The Quality Standard was not fully assessed. Two of seven requirements were assessed and found non-compliant.

A decision was made on 15 December 2022 that the service was non-compliant in requirements 3(3)(b) and 3(3)(d) after a site assessment conducted 8 – 10 November 2022.

Requirement 3(3)(b)

Previously the service did not demonstrate high impact/prevalence risks have been effectively managed for care of each consumer. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* Introduction in April 2023 of a high impact/prevalence risk register to record consumers risks in an accessible location to all clinical and care staff: Assistant directors of care have responsibility for ensuring currency.
* Registered and enrolled nurses received training relating to high impact/prevalence risk and clinical staff received education relating to clinical needs such as falls management, incident classification/documentation and post fall assessment.

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review. Consumers’ clinical risks for example, respiratory condition, weight loss, high risk medications, restrictive practices, hearing aids, and catheter care is identified and management. Implemented changes have resulted in some improvement however the assessment team bought forward evidence the serviced does not demonstrate consistently effective management of high impact/prevalence risks associated with the care of each consumer.

Monitoring/recording documentation does not accurately detail all consumers identified at risk. Via documentation review the assessment team note high risk/impact risks are not identified/appropriately managed for six consumers. Documentation review detail for one consumer experiencing falls, staff have not considered pain and/or unmet behaviours as a possible cause of falling. The assessment team note inappropriate management of one consumer’s pain and unmet behavioural needs result in ongoing negative outcomes. Another consumer’s dietary needs, risk of pressure area and pain management have not been effectively managed. Two consumers risk of pressure injury/wound management not appropriately met, and two consumers diabetes management not managed as per medical officer directives. Management advise of review of consumers needs to ensure appropriate care and referral for medical officer and/or specialist review.

In their response, the approved provider acknowledge deficits in care, supplying documentation detailing immediate and planned actions, plus a commitment to continued monitoring/review to attain compliance. In consideration of compliance, I am swayed by the evidence bought forward by the assessment team demonstrating a lack of effective management of high impact/prevalence risks particularly relating to pressure injury, diabetes, and behavioural management care, resulting in negative consumer outcomes.

I find requirement 3(3)(b) is non-compliant.

Requirement 3(3)(d)

Previously the service did not demonstrate deterioration in a consumer’s condition was identified and appropriately responded to in a timely manner. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* Discussion of consumer’s needs at clinical governance meetings and clinical case reviews
* Education/training for care staff relating to monitoring of consumer’s needs, in particular catheter care and reporting/escalating issues of concern to registered nurses

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review. Implemented changes/improvements have not consistently ensured consumers who experience deterioration or change in condition are identified and responded to in a timely manner.

Via documentation review the assessment team note consumers are not appropriately monitored following unwitnessed falls and/or experiencing possible head injury. While organisational policy/procedures guide staff expectations the assessment team note neurological observations not consistently completed. Document review of 4 consumers files note for two consumers, deterioration following a fall not identified/responded to in a timely manner. Incident reports not consistently reviewed by management, pain management and comfort cares not appropriately implemented. One consumer’s bruising not identified/responded to in a timely manner, nor incidents reviewed by management to identify cause/and implement actions to prevent further falls. Dementia specialist’s directives not implemented for another consumer resulting in ongoing unmet needs.

In their response, the approved provider acknowledge deficits in care, supplying documentation detailing immediate and planned actions, plus a commitment to continued monitoring/review to attain compliance. In consideration of compliance, I am swayed by the evidence bought forward by the assessment team demonstrating a lack of effective systems to ensure deterioration or change in consumers’ health, cognitive/physical function, capacity, or condition is recognised and responded to in a timely manner, resulting in negative consumer outcomes.

I find requirement 3(3)(d) is non-compliant.

# Standard 6

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

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of four requirements was assessed and found compliant.

A decision was made on 15 December 2022 that the service was non-compliant in requirement 6(3)(d) after a site assessment conducted 8 – 10 November 2022.

Previously the service did not demonstrate review and utilisation of feedback and complaints to inform/improve quality of consumer care and services. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* Implementation of process noting recording/classification of a complaint within progress transfer to electronic care planning system to alert management. Management personnel registers within documentation identifying/actioning continuous improvement activity as required. Registered and enrolled nurses received training in relation to new process/classification and interviewed management personnel note process is effective.
* Education relating to identification/complaints classification, utilisation of feedback/complaints to inform continuous improvement activities has been provided
* Training in ‘Key skills: data analysis, driving your improvement’ is to be conducted by the Director of Care – date of which not yet determined.

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review.

Review of feedback and complaints data, continuous improvement plan and feedback from consumers/representatives demonstrate an effective method to capture, review and implement improvements to care and service delivery. Sampled consumers/representatives’ express satisfaction with responses to complaints/feedback leading to improved consumer outcomes. While 2 representatives express some dissatisfaction relating to timeliness of response, management demonstrate methods of regular communication to ascertain satisfaction.

I find requirement 6(3)(d) is 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

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of five requirements was assessed and found compliant.

A decision was made on 15 December 2022 that the service was non-compliant in requirement 7(3)(a) after a site assessment conducted 8 – 10 November 2022.

Previously the service did not demonstrate a workforce which is adequately planned and deployed to ensure safe and quality consumer care. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* A new team leader position allocated in the dementia wing during night shift
* Educational discussions for clinical staff on the importance of assisting/responding to consumers requests for assistance in a timely manner. Two assistant directors of care to regular meet with care staff during discussions between shift handovers.
* Completion of a ‘call bell’ audit identified staff not responding in a timely manner, deficits in the alert system resulting in lack of escalation to registered nurses/assistant directors when ‘call bells’ are not responded to in a timely manner.

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review. Overall, most sampled consumers/representatives consider staff respond to consumer’s requests for assistance in a timely manner and satisfaction with care and service provision. Interviewed staff consider sufficient staff numbers to provide consumers care. Documentation review demonstrates evidence staff who take leave are mostly replaced. Workforce planning processes include staffing adjustments to ensure consumer’s changing needs, mobility and unmet behaviours are addressed. The assessment team bought forward deficits in clinical care which is considered within Standard 3.

In their response, the approved provider supplied documentation detailing actions taken which resulted in identification of further required improvements, plus a commitment to continued monitoring/review to attain compliance.

In consideration of compliance, I am swayed by the volume of satisfaction expressed by consumers, representatives and staff and consider demonstration of appropriate workforce planning is evident.

I find requirement 7(3)(a) is compliant.

# 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 |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers. 2. identifying and responding to abuse and neglect of consumers. 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

The Quality Standard was not fully assessed. Two of five requirements were assessed and found compliant.

A decision was made on 15 December 2022 that the service was non-compliant in requirements 8(3)(c) and 8(3)(d) after a site assessment conducted 8 – 10 November 2022.

Requirement 8(3)(c)

Previously the service did not demonstrate use of effective organisational governance systems, pertaining to information management, continuous improvement, regulatory compliance, feedback, and complaints. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* Scheduled orientation sessions for staff to access procedures/policies including recording monitoring of medications.
* Implementation of process noting recording/classification of a complaint within progress transfer to electronic care planning system to alert management. Management personnel review documentation identifying/actioning continuous improvement activity as required. Registered and enrolled nurses received training in relation to new process/classification and interviewed management personnel note process is effective.
* Education/training for clinical staff regarding incident management and reporting to Serious Incident Response Scheme (SIRS) occurred, plus scheduling of annual SIRS education and discussion at meeting forums.

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review. Effective organisation wide governance systems relating to information management, continuous improvement, regulatory compliance, feedback, and complaints is demonstrated. Documented policies and procedures guide staff in relation to organisational expectations regarding information management systems, continuous improvement, financial management, clinical governance, regulatory compliance and feedback and complaints. The assessment team bought forward some deficits relating to individual consumer documentation; consideration is given within Standard 3.

The chief executive officer (CEO) described the overarching governance framework including policy review, regular communication to consumers/representatives and staff via attendance at meeting forums, email/newsletters, and regular reporting mechanisms. Interviewed care staff demonstrate knowledge of accessing information required to deliver quality care and services including policies and procedures. While the assessment team note some deficits in reporting documentation, the approved provider supplied documentation within their response.

Continuous improvement processes were evident. For example, due to board member acknowledgement of deficits in clinical governance, implementation of a new manager of quality and clinical governance to provide organisational clinical oversight and new processes to ensure capturing of comments/feedback to inform continuous improvement activities. Financial governance is managed at service level by a pre-approved annual budget and expenses approved by business manager. Recent building and capital expenditure occurred. Workforce governance is overseen at an organisational level including processes to address new regulatory requirements and changes in senior clinical staff coverage of both levels within the service. An effective process ensures management are informed of regulatory and legislative changes. Management informs staff and consumers/representatives via regular communication.

The assessment team bought forward evidence some deficits relating to information management; consideration of these issues is within Standard 3. In their response, the approved provider acknowledge gaps detailing immediate and planned actions, plus a commitment to continued monitoring/review to attain compliance.

In consideration of compliance, I am swayed by the evidence of organisational governance systems and consider organisational wide governance systems in relation to each aspect of this requirement.

I find requirement 8(3)(c) is compliant.

Requirement 8(3)(d)

Previously the service did not demonstrate consistently effective risk management systems and practices. They have made some changes since the assessment conducted 8 – 10 November 2022, which include:

* Review of procedure and policy documentation plus education for clinical staff in regard to organisational expectations relating to the definition and therefore reporting requirements relating to falls management.

During the assessment contact visit on 8-9 June 2023 information was gathered through interviews, observations, and document review. Effective organisational systems relating to aspects of this requirement were evident. The organisation has a documented risk management framework, policies and procedures relating to high impact/prevalence risks, identifying, and responding to abuse/neglect of consumers, and a documented incident management system. Staff education has occurred in relation to identification of falls and procedures/policies are to be reviewed. Interview with the CEO note review of risks as a component of the risk management framework and board-run risk management committee providing organisational oversight. Knowledge of service specific risks was demonstrated. Documentation such as board report, clinical governance meeting minutes demonstrate escalation and discussion of issues by board members and cultural safety/person centred care discussions at monthly clinical governance meetings. Board meeting minutes detail review of risk management framework identifying changes as a component of strategic planning, including appointment of an organisational clinical governance manager.

Interviewed staff acknowledge receipt of training regarding identification and management of abuse/neglect and demonstrate awareness of reporting processes and escalation to senior clinical staff. The CEO attends staff meetings and support in addressing SIRS concerns. Review of incidents, trends and quality indicator data is utilised by the board in managing incidents.

The assessment team bought forward evidence some deficits in managing high impact/prevalence risks and inconsistent reporting of incidents; consideration of these issues is within Standard 3. In their response, the approved provider acknowledge gaps in consumer care detailing immediate and planned actions, plus a commitment to continued monitoring/review to attain compliance.

In consideration of compliance, I am swayed by the evidence of organisational governance systems and governing body accountability. I acknowledge deficits in clinical care provision at a service level and have considered consumer impact within Standard 3 requirements. I consider organisational risk management systems are evident.

I find requirement 8(3)(d) is compliant.

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