Performance

Report

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| Name: | Anglican Care Kilpatrick Court |
| Commission ID: | 1026 |
| Address: | 152-156 Brighton Avenue, TORONTO, New South Wales, 2283 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 22 November 2023 to 23 November 2023 |
| Performance report date: | 22 December 2023 |
| Service included in this assessment: | Provider: 3186 Anglican Care  Service: 6568 Anglican Care Kilpatrick Court |

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 Anglican Care Kilpatrick Court (**the service**) has been prepared by T Solomon, 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 December 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Applicable as not all requirements were assessed |
| **Standard 3** Personal care and clinical care | **Not Applicable as not all requirements were assessed** |
| **Standard 4** Services and supports for daily living | **Not Applicable as not all requirements were assessed** |
| **Standard 5** Organisation’s service environment | **Not Applicable as not all requirements were assessed** |
| **Standard 7** Human resources | **Not Applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not Applicable as not all requirements were assessed** |

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 2

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| Ongoing assessment and planning with consumers | |  |
| 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

The Assessment Team identified inconsistencies in relation to the review of care planning and assessments relevant to wound management, however found through documentation review that scheduled reviews were consistently attended, including when consumers return from hospital. Consumers and/or representatives were satisfied with the frequency of reviews.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| 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 |

Findings

Consumers and/or representatives stated they felt the service was responsive to changes in condition and provided enough information to consumers to enable them to make informed decisions. However, The Assessment Team identified through documentation review inconsistencies related to wound management.

Clinical and care staff acknowledged there was an opportunity for improvement related to staff knowledge in identifying and responding to deterioration and the risks related to consumers. Management acknowledged the feedback received from the Assessment Team and staff in relation to identification and management of deterioration across the service. During the exit meeting, management advised they had organised formal education to be provided to clinical and care staff in wound management and documentation to ensure positive outcomes for consumers.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(d) is found 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. | Compliant |

Findings

Requirement 4(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated consumers and/or representatives are satisfied with the dining experience at the service and acknowledge the service has implemented valued changes to the meal service. Consumers confirmed they have options available to select from the menu to suit their preferences. Staff and management stated they have a focus on food and the dining experience with audits and feedback provided from consumers in relation to the menus.

# Standard 5

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| 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 |

Findings

Requirement 5(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated the environment is conducive to the needs and preferences of consumers. Areas are designed to meet consumer needs, remain welcoming and are personalised to ensure a sense of belonging. Consumers and/or representatives stated they are satisfied with the rooms they reside in and that the environment enable independence and privacy. Staff explained that the service is the consumer’s home, and they respect their privacy.

The Assessment Team observed the environment in the memory support unit includes dementia design to facilitate way finding for consumers residing in that space. Pictures have been placed in consumers doors to assist them with finding their rooms, and there are designated quiet lounges for quiet reflection as well as spaces for activities. The service has a range of outside areas including balconies and garden areas for consumers to enjoy with their families. The memory support unit has access to a secure internal courtyard which has shaded sitting areas and trees for consumers to enjoy.

# 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 |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated the workforce is planned to enable the delivery of safe and quality care and services. The staff roster is planned to provide for the needs of the service. Shifts of planned and unplanned leave are normally replaced by offering additional shifts or overtime to the permanent and casual staff. In addition, the service has access to nursing agencies who provide staff to fill vacant shifts. Management stated they are trying to minimise the use of agency staff.

Consumers and/or representatives confirmed they are well cared for, and staff are meeting their care needs. Consumers confirmed when they use the call bell staff normally respond in a reasonable time. Staff stated they normally have enough time to complete their duties during their shift.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated the performance of staff is regularly monitored and reviewed, and that staff are required to have a performance appraisal completed annually. The service has planned this according to a schedule allocating times throughout the year. Records show this schedule is largely being followed with outstanding appraisals to be conducted by the end of the year.

Review of staff performance is also done informally through the review of clinical data, incident reports, feedback from consumers and staff, and through the supervision and observation of senior staff and management. Staff confirmed they had completed their performance appraisal or were scheduled to have an appraisal completed soon.

# Standard 8

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| 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)(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

Requirement 8(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated how it supports consumers to be engaged in the development, delivery and evaluation of care and services.

The organisation conducts monthly residential care managers meetings which includes discussion of complaints or concerns from each service. This meeting includes the chair of the Board and the chief executive officer. It is an opportunity to provide feedback from the consumers of their services to the Board.

At the service level consumers and/or representatives are given the opportunity to contribute to the development, delivery and evaluation of care and services through regular consumer meetings, held every second month. These meetings include discussions relating to food and lifestyle services.

Consumers and/or representatives confirmed the service is well run and stated they were able to make comments, suggestions, and complaints. In addition to the regular meetings, management explained they encourage and support consumers and/or representatives to participate in the development, delivery and evaluation of care and services in other of ways, including through providing feedback anonymously.

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it has effective governance systems in place for information systems, continuous improvement, feedback and complaints, financial governance, workforce governance and regulatory compliance.

The service has information systems to provide stakeholders with the information they need. Consumers are provided information about the care and services provided when they first enter the service and on an ongoing basis. Staff have access to relevant information, and communication processes for staff include the electronic clinical documentation system, intranet, handover at each shift, messaging systems, emails, and the education/training program.

The service has a continuous improvement system in place and identifies opportunities for improvement through input from consumer feedback, complaints, audits, surveys, staff suggestions, review of clinical indicators, incidents, meetings, organisational initiatives, and external reviews. The continuous improvement process is monitored at a local and organisational level.

Changes to aged care regulation and legislation are monitored by the organisation. The organisation’s quality team oversees the review and updating of policies and procedures and the Board approves policies and procedures for use at the service. The organisation provides updates and notifications to management and staff of any new regulatory requirements and any new or updated policies and procedures. Relevant communication and training are provided to staff in relation to changes and new requirements.

The Assessment Team identified inconsistencies in the review and identification of pressure injuries for consumers with complex needs, however the service responded with actions implemented to address the inconsistencies.

The organisation has an overarching risk management framework, and risks are identified at the service through assessments, surveys, analysis of clinical data, feedback from staff, and complaints. Consumers identified with high impact or high prevalence risks are reviewed at the weekly clinical leadership meeting. The clinical leadership team also review all incidents and complaints.

The organisation has introduced a new electronic incident management system across all its services. The new system is to improve the visibility, trending, and communication in relation to risk management, incident management, feedback, and complaints.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found Compliant.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated it has systems in place to enable the service to deliver safe and effective clinical care and ensure consumers are enabled to live the best life they can. Staff have resources available enabling them to understand the expectations from the organisation in relation to the delivery of quality and safe care and services.

Staff were able to describe how they deliver sound antimicrobial stewardship, using non-pharmacological strategies and testing prior to seeking medical interventions. Review of the service’s documentation in relation to the use and minimisation of restrictive practices showed they actively monitor and review consumers on chemical restraint and psychotropic medications. All consumers listed in the psychotropic registered had appropriate diagnosis and consent.

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)