Performance

Report

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| Name: | Arthur Blackburn VC Gardens |
| Commission ID: | 0537 |
| Address: | 821 Ocean Drive, PORT MACQUARIE, New South Wales, 2444 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 20 February 2024 to 22 February 2024 |
| Performance report date: | 15 April 2024 |
| Service included in this assessment: | Provider: 643 RSL LifeCare Limited  Service: 19290 Arthur Blackburn VC Gardens |

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 Arthur Blackburn VC Gardens (**the service**) has been prepared by Therese 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 19 March 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 1(3)(a)

* Ensure each consumer is treated with dignity and respect, specifically in relation to wound photography, staff practices and in consideration of consumer preferences.

Requirement 3(3)(b)

* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer, specifically related to wound management, falls management, behaviour management and incident management.

Requirement 6(3)(a)

* Ensure consumers, their family, friends, carers, and others are encouraged and supported to provide feedback and make complaints.

Requirement 7(3)(a)

* Ensure 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.

Requirement 7(3)(c)

* Ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices, specifically in relation to management of high-impact and high-prevalence risks associated with the care of consumers.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not Compliant |

Findings

Mixed feedback was received from consumers and/or representatives in relation to consumers being treated with dignity and respect. Whilst some consumers found the service was valuing their identity, culture and diversity, other consumers and representatives indicated consumers were not treated with dignity and respect. Staff interviews and observations did not support that consumers were consistently treated with dignity and respect.

Wound photography documentation reviewed showed multiple consumers photographed with their dignity not respected. The wound photographs did not demonstrate staff had considered consumer dignity.

A consumer representative reported an example of unprofessional and undignified behaviour they observed by a staff member when a consumer was transferred to hospital, and the Assessment Team observed staff members entering consumer rooms without knocking or without waiting for acknowledgement prior to entering the room. Consumer representatives reported that staff are disclosing inappropriate information to consumers and consumer representatives, including information about other consumers and internal staff conflict.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to sending a memo to all staff regarding treating consumers with dignity and privacy, provide education to staff on consumer dignity and respect, provide education to staff on wound management and wound photography, the purchase of two new tablets to assist staff with wound photography.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 1(3)(a) is found Non-compliant.

# 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. | Not Compliant |

Findings

The service did not demonstrate effective management of high-impact and/or high-prevalence risks, with deficits identified in the management of high-impact or high-prevalence risks associated with consumer care. Deficits in effective clinical oversight was evident when reviewing consumers with high-impact or high-prevalence risks, specifically in relation to medication management, clinical oversight of care and clinical incident review. The service did not demonstrate effective oversight of staff practices to ensure high-impact, high-prevalence risks for each consumers’ care is mitigated as needed.

Management identified falls as their biggest high prevalence risk currently at the service. Consumer and/or representative feedback regarding care was inconsistent, with some representatives raising concerns in relation to clinical oversight of consumer care and the management of risk. Staff did not demonstrate a sound knowledge of high-impact, high prevalence risks for consumers.

Review of consumer medication charts indicated there is no indication detailed for the administration of as needed medications and that staff are administering as required medication without the indication for use. As a result, staff were not aware of when, and in what circumstances they as needed medication was to be administered to consumers.

Three consumer representatives reported they have witnessed ineffective and unsafe medication administration practices conducted by clinical staff at the service, including clinical staff having multiple consumers’ medication pre-dispensed in medication cups stacked on top of each other, as well as a registered nursed having four insulin pens in her pocket at the same time when administering insulin to their relative. Two consumer representatives reported they have found medication on the floor of their relative’s room, as well as on the chairs in common areas when assisting their relative.

Behaviour support plans reviewed did not reflect individualised consumer centred interventions to ensure effective management of consumers changed behaviours. Documentation did not reflect that identified behaviours in the behaviour monitoring charts had a comprehensive assessment of the behaviour, the trigger identified, and strategies to be implemented to support the consumers and mitigate any risks associated with that behaviour. These behaviours had not been included in the behaviour support plan to direct individualised consumer care and mitigate the risk of behaviours escalating and the potential use of inappropriate chemical restraint. The identification of the high impact risks and high prevalent risks of consumer behaviours and staff understanding of effective individualised interventions was not consistently evident in consumer documentation and staff interviews.

Documentation does not demonstrate there is effective incident investigation and evaluation processes, and this has led to negative impacts for some consumers. Most representatives indicated they had been informed when an incident occurred however, they did not indicate that staff provided details of the incident review and how this would improve care outcomes for the consumer. Staff did not demonstrate an understanding of incident review and the quality systems had not identified deficits in incident management.

The Assessment Team identified deficiencies in pressure area care and nutrition and hydration management. The service did not demonstrate an effective system in place for managing pressure area care strategies implemented for consumers such as air mattresses, with staff demonstrating limited knowledge in relation to individualised setting requirements, or who is responsible for ensuring the correct pressure setting for each individual consumer.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to all registered nursed to complete medication competency, provide education to staff on wound management, enrol the clinical care manager in the Wound Management Project, the facility manager to meet with agency managers to discuss agency staff performance, provide falls management education to staff.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Non-compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Not Compliant |

Findings

Consumers and/or representatives indicated they are not encouraged and supported to provide feedback and raise complaints, and that management is not responsive when they raise concerns or complaints. Some consumers and/or representatives indicated they fear retribution from staff and management should they raise any concerns and therefore they do not feel supported and encouraged to make complaints and provide feedback.

Consumers and/or representatives indicated the communication at the service was ineffective and when they voiced their concerns at consumer/representative meetings they are constantly left wondering what the outcomes of their feedback and complaints are. Some representatives indicated they are not encouraged to provide agenda items for the consumer/representative meetings which are part of their feedback and complaints.

Some representatives expressed fear of retribution and made the Assessment Team commit to not identifying them prior to them providing their feedback. One representative reported they would not provide their feedback unless the Assessment Team committed to deidentifying them, and another representative indicated they did not want their name to be used, as they feared retribution against their relative.

Representatives also reported that management are not facilitating the complaints process, and that consumers and representatives are made to feel like they are causing trouble. A consumer indicated management do not listen and respond to their complaints.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to enrolling the facility manager in a leadership course, daily walk arounds to be commenced by the facility manager, discussing the complaints process at resident/relative meetings.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 6(3)(a) is found Non-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. | Not 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. | Not Compliant |

Findings

The service did not demonstrate an effective process to ensure that the workforce is planned and deployed to enable to delivery and management of safe and quality care and services for the consumers. Consumer impact was found in relation to, medication management, behaviour management, clinical oversight, incident review and consumers receiving the wrong meals.

Staff indicated that they did not always have time to complete their duties and meet consumer needs. Consumers and/or representatives provided negative feedback regarding the high use of agency staff. Permanent and agency staff reported a culture of bullying and intimidation at the service which is impacting on their roles and willingness to work at the service. The Assessment Team observed, and documentation supports that agency staff make up a significant percentage of the services workforce.

Consumers and/or representatives indicated agency staff do not know consumers, or their individual care needs. Two consumers indicated that while the staff are lovely, they do not seem to have any training before they start. Some consumers indicated there is usually a set person that assists with meal delivery, however they indicated there has not been one for some time and consumers are waiting for their meals, resulting in consumers receiving cold meals.

Consumers and/or representatives provided feedback that they found the staff airing the conflict and issues within the service upsetting. Consumers and/or representatives described a poor staff culture in relation to divulging information about other consumers at the service, as well as internal staff conflict to consumers.

A consumer representative indicated that there are not enough leisure and lifestyle staff, care staff or laundry staff at the service. They advised the activities in the memory support unit are repetitive and do not cater to consumer’s individual needs. Consumers and/or representatives indicated as a result of the staffing issues there is inconsistencies in clinical monitoring and practices. Some representatives indicated there is a lack of continuity of care in the memory support unit due to the high use of agency staff and found this has impacted on the effective behavioural management and engagement of consumers.

Staff reported that the workforce did not always work to support each other to deliver consumer centred care. Permanent and agency staff reported a culture of bullying and intimidation by some permanent staff towards agency and new staff. Both agency and permanent staff indicated that some agency staff will not work at the service due to this culture.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to enrolling the facility manager in a leadership course, weekly meetings by the facility manager and the recruitment team to fill vacant roles, facility manager to organise training for staff on various topics including medication, behaviour management and dietary requirements.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 7(3)(a) is found Non-compliant.

Most members of the workforce have appropriate qualifications in relation to their roles such as registered nurses and care staff. A review of documentation showed competencies were mostly up to date for staff, however deficiencies were identified in relation to staff knowledge and skills in relation to providing individualised care to consumers, medication management, incident management and behaviour management.

Consumers and/or representatives raised concerns regarding the high use of agency staff, turnover of permanent staff and skills of new and agency staff. Most consumers, representatives and staff raised concerns in relation to insufficient orientation and supervision of new and agency staff members. Staff reported there is insufficient orientation for new and agency staff. Management advised that new staff complete an orientation, have three buddy shifts and new staff are supervised by experienced staff. However, some new staff indicated they only received one buddy shift and do not get supervised by experienced staff.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to enrolling the facility manager in a leadership course, the facility manager to organise training for staff on various topics including medication, behaviour management and dietary requirements.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 7(3)(c) is found Non-compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not Compliant |

Findings

The Assessment Team identified that whilst there are risk management systems in place, they were not effective in identifying and managing risks. The regional manager indicated there are organisational risk management systems and practices to effectively manage high impact and high prevalence risks, identify abuse and neglect of consumers and support consumers to live the best quality of life they can.

The regional manager advised the service enters incidents into the electronic incident and risk management system. The system alerts the level of risk based on incident category and the organisational risk and compliance manager reviews serious incidents that are reported as well as high rated risk incidents. The regional manager has oversight of the service and incidents and risks and is responsible to report upwards to the general manager. The regional manager indicated service level incidents are discussed at the service’s leadership meetings, trended, and data is forwarded to the clinical governance team.

The regional manager indicated falls and pressure injuries/wounds were the main high-impact, high-prevalence risk from an organisational perspective. The Assessment Team enquired if the organisation identified the high agency use as a potential high-impact, high-prevalence risk for consumer care, and they acknowledged recruitment and agency use was a risk.

In responding to risks associated with neglect and abuse there is a process within the organisation to manage and support consumers who are at risk as a result of neglect and abuse. The regional manager indicated the organisation supports consumers to live the best life they can through the four pillars/values that guide organisational processes and practices.

However, the service and organisation are not effectively identifying and managing high-impact and high-prevalence risks associated with consumer care or ensuring the risks associated with the poor staff culture and agency use are managed to mitigate risks and impact on consumers.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance, including but not limited to engaging an external independent auditor to review the facility and its current processes.

I acknowledge the actions taken by the approved Provider, however the actions implemented will take time to become embedded into daily practice and will need to be evaluated for effectiveness. Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found Non-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)