Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Bracken House Dubbo |
| Service address: | 315 Macquarie Street DUBBO NSW 2830 |
| Commission ID: | 0215 |
| Approved provider: | United Protestant Association of NSW Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 July 2023 to 19 July 2023 |
| Performance report date: | 22 August 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 Bracken House Dubbo (**the service**) has been prepared by G Jones, 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 25 July 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **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

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 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement 1(3)(a) was found non-compliant following a Site Audit 29 March 2022 to 31 March 2022 as consumers stated they were not treated with respect by all staff. Since that time the service has undertaken improvement activities including staff training, increased oversight of staff as well as seeking regular consumer feedback. The actions taken in response to the non-compliance have been effective.

Consumers and representatives interviewed provided information about staff making the consumer feel respected and valued as an individual, with their identify, culture and diversity valued. Staff were observed interacting with consumers respectfully and were familiar with consumer’s backgrounds. Care and service documentation records information on consumers’ background and life journeys and this aligned with what consumers and staff said. The service has policies which outline what it means to treat consumers with dignity and respect.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | 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)(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

Requirement 3(3)(a) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care. Staff were not always following policies and procedures for management of pain, diabetes, restrictive practices, wounds and bowel care. Since that time the service has undertaken improvement activities including staff training regarding certain types of medications, wound and falls management. The actions taken in response to the non-compliance have been effective.

All consumers and their representatives interviewed considered they received personal clinical care that is safe and right for them, provided in a timely manner as per their needs/preferences and optimises their health and wellbeing. A review of care and planning documentation identified care delivery is individualised and found to be safe, effective and tailored to the specific needs and preferences of each consumer. The organisation has skin care and wound policies and procedures that reflect best practice guidelines in the management of skin integrity, pressure injuries and wounds. These documents are readily accessible to guide staff practice. Staff interviewed demonstrated knowledge of individual consumer’s personal and clinical care needs and preferences and how they reference guidance policies and procedures when and as needed to support this care.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 3(3)(b) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate there was an effective system in place to manage high impact and high prevalence risks identified in relation to skin integrity, wound, and falls management, weight loss and pressure area care. Since that time the service has undertaken improvement activities including staff training about the management of high impact high prevalent risks and increased the monitoring of new consumers to ensure identified risks are managed in a timely manner. The actions taken in response to the non-compliance have been effective.

Consumers and representatives sampled provided feedback that consumers with high prevalence high impact risks including falls or pressure injuries were satisfied with the care and management of these risks. Review of sampled consumer care and service documentation indicated as risks were identified they were entered into the service’s electronic care management system (ECMS) including planned interventions to minimise risk. Falls management plans are in place after a consumer fall and all falls are thoroughly investigated and mitigation strategies put in place. Pressure injury risk was also managed appropriately.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 3(3)(g) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate consistent management of standard and transmission-based precautions to prevent and control infections. Management and staff were observed not appropriately wearing personal protective equipment (PPE), clinical waste was not being managed safely, staff were not conducting appropriate hygiene practices, and effective protocols were not in place in relation to COVID-19 entry screening. Since that time the service has undertaken improvement activities including staff training, changes made to the management of clinical waste, and improved entry protocols for COVID-19. The actions taken in response to the non-compliance have been effective.

The actions taken in response to the non-compliance have been effective.

Management and staff interviewed demonstrated an understanding of antimicrobial stewardship and the principles of infection prevention and control. The service had an outbreak preparedness/management plan and associated documents in place to guide staff in the event of an outbreak. Processes are in place to support antimicrobial stewardship and staff were observed wearing PPE and adhering to hand hygiene.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate the meals provided to consumers are varied and of suitable quality and quantity. In particular, staff were using items of expired food and some consumer dietary assessments were found to be inaccurate. Since that time the service has undertaken improvement activities including regular auditing of food and the cleanliness of the kitchen and ensuring documentation accurately records consumer dietary preferences. The actions taken in response to the non-compliance have been effective.

Consumers and representatives interviewed said the service provides a variety of meals which they feel are of a suitable quality and quantity. The service regularly seeks feedback on the menu and catering staff make changes accordingly. The menu is planned in consideration of consumer feedback and with dietician review. Care and catering staff were knowledgeable of the specific dietary needs and preferences of consumers. The kitchen and dining rooms were observed to be clean, and consumers appeared to enjoy the dining experience.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 5

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | |  |
| 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

Requirement 5(3)(b) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate the service environment was safe, clean and well-maintained. Consumers were not satisfied with the cleanliness of their rooms and doors were locked preventing them moving freely. It was found the fire statements were out of date, areas were poorly maintained, and hazards present. Since that time the service has undertaken improvement activities including staff education around cleaning, areas have been made safe and fire certification obtained. Changes have been made to the service environment to assist those with a cognitive decline including new signage and noise reduction initiatives. A key pad opening system introduced to aid consumers’ entry and exit. The actions taken in response to the non-compliance have been effective.

The service is well presented, safe and clean. Consumers and representatives stated they were satisfied with the cleanliness of their rooms and the common areas of the service and feel comfortable in the service environment. Consumers were observed to move freely, both indoors and outdoors.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 5(3)(c) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate the furniture, fittings and equipment was safe, clean, well-maintained, and suitable for the consumer. Consumers were not satisfied with the cleanliness of their rooms, not all scheduled work had been completed, testing and tagging reports were not available and equipment was broken. Since that time the service has undertaken improvement activities including new furniture purchased, equipment replaced, maintenance schedules implemented and improved audit schedules to monitor cleanliness.

Consumers and representatives stated they were satisfied with the cleanliness of their rooms and the common areas of the service. Consumers stated that equipment they use is regularly checked maintained. A review of the service’s preventive and reactive maintenance logs showed preventive maintenance tasks are up to date. Furniture in communal areas were observed to be clean, in satisfactory condition and in plentiful supply. An assets management plan is placed to replace older equipment with new.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement 6(3)(c) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate an open disclosure process is consistently used when things go wrong. While consumers and representatives consider complaints are generally responded to, they expressed dissatisfaction they are not consistently included in the process, informed of the outcome and/or offered an apology. Since that time the service has undertaken improvement activities including providing staff education, introducing feedback boxes and providing more information to consumers in relation to complaints trending. The actions taken in response to the non-compliance have been effective.

The service’s complaints and compliments register showed feedback, compliments, and complaints have been managed in accordance with the organisation’s feedback and complaints policy. The service’s feedback and complaints policy include a section explaining open disclosure and staff interviewed were able to explain how they applied open disclosure should they receive feedback or a complaint. Sampled consumers and representatives said the service addressed any concerns they had in a timely manner and when there was an issue, provided an apology.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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

Requirement 7(3)(a) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate adequate staffing levels to ensure quality and effective services are provided in a timely manner. Since that time the service has undertaken improvement activities including recruiting new staff and trialling different ways of working to ensure safe care is delivered. The actions taken in response to the non-compliance have been effective.

Overall consumers and representatives interviewed were happy with the care and services provided at the service. Management was able to explain how its workforce is planned to meet the needs of the consumers and provide safe and quality care. Call bell response times indicated they are mostly answered within 10 minutes. All staff interviewed indicated they were able to complete their duties within the allocated shift and rarely worked short. Review of the staff roster and allocation sheets for the fortnight prior to the Assessment Contact identified most vacant shifts were filled by staff and un-planned leave covered by staff commencing duties early or finishing later, utilising their casual pool, or as a last resort, using agency staff.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

Requirement 8(3)(c) was found non-compliant following a Site Audit 29 March 2022 and 31 March 2022 as the service was unable to demonstrate an effective governance system to ensure a sufficiently staffed workforce and an effective complaints management process to meet consumer needs. Since that time the service has undertaken improvement activities including developing strategies to retain existing staff and greater management oversight of the complaints process. The actions taken in response to the non-compliance have been effective.

The organisation was able to demonstrate effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Information flows from the Board to staff who have ready access to the information they need. Continuous improvement opportunities are identified from a variety of sources, and this drives the organisations continuous improvement process. Staff reported they have sufficient budget for every-day expenditure and high value projects as well as training support. Workforce governance ensures staff have clear accountabilities and responsibilities and are sufficiently skilled and qualified to provide safe, respectful, and quality care and services to consumers. Necessary communications occur at organisational and service level to ensure management and staff are aware of any regulatory changes and when this happens policies and processes are adjusted, and training and information provided. The organisation’s feedback and complaints policy include a section explaining open disclosure and the organisation demonstrated feedback and complaints are reviewed and used to improve the quality of consumer care and services.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

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)