Performance

Report

**1800 951 822**

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| Name of service: | Bundaleer Gardens Hostel |
| Service address: | 142a Cameron Street WAUCHOPE NSW 2446 |
| Commission ID: | 0434 |
| Approved provider: | Apollo Care Operations Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 July 2023 to 5 July 2023 |
| Performance report date: | 10 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 Bundaleer Gardens Hostel (**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 7 August 2023

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | 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 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 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

Requirement 2(3)(e)

Information gathered through interviews, observations and document review demonstrated the service has a system in place to review consumers care and services on a regular basis as well as following an incident or a change in a consumer’s condition. The current computerised system enables staff to schedule tasks such as care plan reviews and case conferences to prompt and remind registered nurses.

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

# 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. | 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)(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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Requirement 3(3)(a)

The service demonstrated consumers receive care that is within best practice guidelines, is personalise, and aims to optimise consumer health and wellbeing. Staff and management were able to describe how they provided personalised care for consumers and demonstrated use of behaviour management plans and care plans. A review of consumer documentation indicates care is being tailored to consumer need. Consumers and their representatives spoke highly of staff attitude and the delivery of care provided by the service.

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

Requirement 3(3)(b)

The service demonstrated that high impact/high prevalence risks are effectively managed though their governance systems and procedures. Management and staff were able to describe effective management of risks identified. Management said that they monitor key clinical indicators related to risks, including falls, behaviour, infection, medication management, weight management, skin integrity, pressure injuries and wounds. Risks identified are shown to be reflected in care planning documentation and hand over documents, and the implementation of interventions to minimise risk were implemented.

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

Requirement 3(3)(d)

The service demonstrated that consumers who have experienced a change in their condition cognitive or physical function, capacity and/or mental health have their needs recognised at responded to in a timely manner. Management and clinical staff said that when a consumer’s condition deteriorates, the registered nurse on duty liaises with clinical management and the consumers’ MO to ensure timely and appropriate care and/or supports are provided. Communication and consultation occurs with the consumer’s representative. Documentation in clinical notes confirms this process. Consumers and representatives told the Assessment Team that they are happy with the staff response when consumers need treatment.

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

Requirement 3(3)(f)

The service demonstrated that referrals are attended. For consumers sampled, care planning documentation indicated that referrals were timely and appropriate to optimise consumer health. Documentation indicates the input of allied health professionals including DSA, speech pathologists, dieticians, geriatricians, physiotherapists and wound specialists. The implementation of their care recommendations are reflected in documentation and demonstrated by clinical and care staff.

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

# 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

Requirement 8(3)(c)

The service has recently transitioned to the organisation’s new intranet system which enables management and staff at each service within the group to access the quality management system. This includes staff being able to access up to date policies and procedures, forms, job descriptions and staff handbook via their mobile telephones. Staff confirmed they have access to information related to consumers care needs through verbal shift handovers, handover sheets and via the computerised care documentation system. The organisation’s quality governance team have access to the service’s clinical system and registers to remotely monitor and conduct audits. At a service level, checks are being undertaken on care documentation to ensure that staff are complying with relevant legislation including SIRS as well as recording information in the relevant document.

The community general manager and training and quality compliance officer advised that opportunities for improvement are able to be identified through audit and survey results, clinical indicator data as well as consumer and representative feedback. Each service within the group has a PCI which enable management at a service and organisational level to monitor actions being taken to make improvements.

The community general manager advised there is an annual budget developed including capital expenditure items. The residential service manager has authority to make routine purchases under a designated amount when needed. Larger expenditure items are escalated through to senior management for approval. Evidence of this process working to purchases equipment needed for care and service delivery was seen by the Assessment Team.

Recruitment is supported by the human resource administrative team which covers advertising for vacant positions and screening prior to interviewing. The community general manager advised that the master roster was reviewed in conjunction with staff to provide some shift certainties for staff. Work was undertaken with the staff member managing the roster regarding how shift replacements would be managed resulting in a reduction is shift vacancies.

The community general manager advised that the organisation subscribes to various government websites to track and monitor legislative changes. There are monthly care governance meetings and infection prevention and control meetings at which legislative updates are discussed. Policies and procedures are reviewed with regard to legislative updates and amended when required. Relevant information is then referred to the services within the group for information and/or action. The organisation receives monthly reports from each service within the group and these, as well as other key operational topics, are discussed at the monthly management meeting with the chief governance officer and other key team members. Compliance with legislative changes is also able to be monitored through audits conducted as part of the quality program.

Feedback and complaints received through feedback forms, emails and verbally are logged into an electronic system by the residential service manager. The governance team are able to log into the system to monitor and review complaints trending. The governance officer reports to the board on data from each site to determine if any issues are trending and that action is being taken on issues.

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

Requirement 8(3)(d)

The organisation has a risk management system which includes the electronic recording of incidents in the clinical documentation system. Staff members are aware of the importance of reporting incidents to the registered nurses as well as commencing an incident report. Registered nurses advised they monitor incident reports and conduct initial investigations. Incident reports are also reviewed by the clinical coordinator and/or the residential service manager. Clinical indicator data is reviewed at a site level as well as organisational to determine any trends which may be occurring.

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The Approved Provider, in their response to the report, accepted the Assessment Team’s 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)