Performance

Report

**1800 951 822**

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| Name of service: | Calvary Lower Plenty Garden Views |
| Service address: | 390 Main Road LOWER PLENTY VIC 3093 |
| Commission ID: | 4093 |
| Approved provider: | Calvary Aged Care Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 August 2023 |
| Performance report date: | 25 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 Calvary Lower Plenty Garden Views (**the service**) has been prepared by N Eastwood 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.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | 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 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 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 5 September 2022 to 7 September 2022.

At the time of the Site Audit the service was unable to demonstrate assessment and care planning considered current risks to consumer health and well-being specifically in relation to updates to reflect medical specialist recommendations, management of changed behaviours, fluid restrictions, and smoking.

The service has implemented several effective actions in response to the identified non-compliance, clinical management maintain a comprehensive register of risks to the health and well-being of each consumer, as well as ensuring these are effectively communicated to staff at handover, and the daily clinical huddle. Care planning and assessments are monitored to ensure completion on admission and at scheduled intervals, monthly reporting of risks is completed and the service has updated the psychotropic register to ensure consistency with best practice.

During the Assessment Contact conducted on 1 August 2023, the service demonstrated it identifies current risks to consumer health and wellbeing and develops care plans that support staff to deliver safe care. Consumers and representatives confirm the service is aware of risks to consumer health and well-being and delivers safe level of care. Staff were able to identify high-impact and high-prevalence risks to consumers well-being and described how current risks and care needs are communicated through handover sheets and clinical huddle meetings. The Assessment Team reviewed consumer care documentation which reflected individualised assessment and care planning including risks associated with personal choice such as smoking and complex care needs. The Assessment Team noted the documentation identifies risks to consumer health and well-being and includes strategies to mitigate these risks.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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

The service was previously found non-compliant with this requirement following a Site Audit performed between 5 September 2022 to 7 September 2022.

At the time of the Site Audit the service was unable to demonstrate that meals provided to consumers were of a suitable quality. The service did ensure did not ensure the food served to consumers was commensurate with their documented preferences and choices.

The service has implemented several effective actions in response to the identified non-compliance, including changes to staff, daily meetings to discuss feedback, improvements, and updating consumer preferences. Training has been provided related to consumer and dining experience, staff undertake food surveys.. Consumer dietary preferences have been updated in individual consumer dietary assessments.

During the Assessment Contact conducted on 1 August 2023, the service demonstrated that meals were of good quality and sufficient quantity as well ensuring meals were provided in accordance with consumer dietary requirement and preferences. Consumers confirmed they receive enough food and, where applicable, receive meals in accordance with specific dietary needs. Staff confirmed they received training from the service to ensure they monitor and follow consumers dietary requirements. The Assessment Team reviewed care plans and printed handover sheets noting both contained information regarding consumer dietary requirements.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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 |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was previously found non-compliant with requirements 7(3)(a) and 7(3)(e) following a Site Audit performed between 5 September 2022 to 7 September 2022.

At the time of the Site Audit the service was unable to demonstrate the numbers and mix of staff were sufficient for the delivery and management of safe and quality care and services, and effective assessment, monitoring, and review of staff performance

The service has implemented several effective actions in response to the identified non-compliance including ongoing recruitment, access to staffing through alternate sites, newly appointed management team and a schedule of annual staff appraisals.

During the Assessment Contact conducted on 1 August 2023, the service demonstrated the workforce is planned and adequate in numbers and skill mix to enable the delivery of safe and quality care. Consumers and representatives described how there is staff available when they need them, and they do not have to wait for long periods when utilising their call bell. Most staff described how there are sufficient levels of staff across the service and said shifts are filled during unplanned or planned leave. The Assessment Team reviewed information related to ongoing recruitment processes as well as the working roster from 17 July to 31 July 2023 which identified most vacant shifts were filled by casual, permanent or staff from a nearby service across the 2-week period. The Assessment Team reviewed monthly call bell data which demonstrated most call bell responses were within the benchmark timeframe of 10 minutes for the service.

The Assessment Team noted that the service now has a systematic approach to the management of staff performance. Management described how they ensure all staff participate in the performance appraisal process and explained how they manage unsatisfactory performance. Staff confirmed they have participated in the performance appraisal process. The Assessment Team observed documents that demonsrtae the scheduling of staff performance appraisals throughout the year and staff participation in performance appraisals.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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 |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 5 September 2022 to 7 September 2022.

At the time of the Site Audit the service was unable to demonstrate compliance with regulatory requirements, including restrictive practices, ensuring organisation governance frameworks were being adhered to, including police checks and organisational policies were being followed.

The service has implemented several effective actions in response to the identified non-compliance, monthly clinical governance and clinical leadership meeting occur to analyse trends, Serious Incident Response Scheme (SIRS), along with implementing corrective actions. The service has undertaken additional recruitment of senior management positions as well as infection prevention and control (IPC) lead, along with the appointment a psychotropic champion.. Staff have current police checks and are reminded two weeks prior to expiry dates.

During the Assessment Contact conducted on 1 August 2023, the service demonstrated it has effective organisational governance systems in place in relation to information management, feedback and complaints, continuous improvement, regulatory compliance, and workforce governance. Management and staff described how information is shared and communication with representatives is maintained in relation to restrictive practices. Management outlined workforce governance strategies including completion of police checks prior to commencement of employment and review of the roster on 6 weekly and daily basis in response to unplanned leave. The Assessment Team reviewed the SIRS register and incident management system which demonstrated reportable incidents were consistent with the reporting requirements.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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)