Performance

Report

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| Name of service: | Coroneagh Park Hostel |
| Service address: | 50 Ironcliffe Road PENGUIN TAS 7316 |
| Commission ID: | 8044 |
| Approved provider: | Respect Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 14 December 2022 to 15 December 2022 |
| Performance report date: | 12 January 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 Coroneagh Park Hostel (**the service**) has been prepared by C Spiller, 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 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 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** |

An unannounced Site Audit was conducted at the Coroneagh Park Hostel during the period from 14 December 2022 to 15 December 2022. The purpose of the visit was to assess the service against the Requirements assessed as not met during a Re Accreditation Site Audit conducted on 5 October 2021 to 7 October 2021. The Requirements under review were Requirements 1(3)(e), 3(3)(a), 4(3)(a), 7(3)(a), and 8(3)(d).

Where the Quality Standard is Met, all requirements of that Quality Standard have been assessed as Met.

Where the Quality Standard is Not Met, one or more requirements of that Quality Standard has been assessed as Not Met. Note that this does not mean that 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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |

Findings

I am satisfied this Requirement is compliant.

This Requirement was found non-compliant following a Site Audit from 5 October to 7 October 2021 with the service unable to demonstrate that information provided to consumers is clear, easy to understand and enables them to exercise choice.

During the Assessment Contact on 5 December 2022 to 7 December 2022 the service demonstrated information is provided to consumers in a range of ways and that this is mostly timely, accommodates those whose primary language is not English and is considerate of consumers who may be impacted by sensory deficits and/or cognitive decline. Overall, consumers and their representatives said information they receive allows them to make informed decisions. The Assessment Team observed notice boards in the communal dining areas to communicate the daily menu, and pamphlets and posters providing information on a range of services including advocacy groups, diversity, health issues and counselling displayed.

The organisation has implemented several actions in response to the non-compliance, which have been effective. Actions included; Education on care planning evaluation and review, staffing increase allowing senior staff time for work through documentation and assessment gaps, and timely notification and communication post incidents.

# 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 |

Findings

I am satisfied, on balance, this Requirement is compliant.

This Requirement was found non-compliant following a Site Audit from 5 October to 7 October 2021 with the service unable to demonstrate compliance with legislative requirements for the implementation and monitoring of restrictive practices, in particular chemical restraint and with behaviour management not meeting contemporary guidelines.

During the Assessment Contact on 5 December 2022 to 7 December 2022 the service demonstrated the provision of individualised personal and clinical care that is mostly safe and right for each consumer living at the service with documentation generally demonstrating that consumers’ changed behaviours, wounds and pain are effectively managed. All consumers and representatives said they were satisfied with the provision of clinical and personal care for consumers.

The Assessment Team found evidence of informed consent for the use of psychotropic medication being obtained by the prescriber and individualised behaviour support plans in place for all consumers. Overall, wound management aligned with policy directives and there was a planned approach to pain assessment, monitoring and management.

The organisation has implemented several actions in response to the non-compliance identified at the Site Audit 5 October to 7 October around these deficits which have been effective.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |

Findings

I am satisfied this Requirement is compliant.

This Requirement was found non-compliant following a Site Audit conducted during 5 October 2021 to 7 October 2021. The service was not able to demonstrate consumers are provided with the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

During the Site Audit conducted on 14 December 2022 to 15 December 2022, the Assessment Team found that the service has introduced a lifestyle and activity plan that aligns with the interests of the current consumers, including those in the memory support unit. Consumers were satisfied with the variety of activities offered by the service. Care plan documentation has a specific lifestyle section, personalised to include the individual consumers current interests in activities as well as what they enjoyed and were able to do in the past. Notes were also made by staff indicating whether the consumer required one on one or encouragement to attend group activities.

# 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 |

Findings

I am satisfied, on balance, this Requirement is compliant.

This Requirement was found non-compliant following a Site Audit conducted during 5 October 2021 to 7 October 2021. The service did not adequately demonstrate how they plan the number and mix of staff to enable safe and quality care and services for consumers.

During the Assessment Contact conducted on 14 December 2022 to 15 December 2022, the Assessment Team found the service has made changes to more effectively plan the number and mix of staff to enable safe and quality care and services.

Rostering staff advised the Assessment Team that the roster is currently at full capacity. The master roster aligns with the organisation’s ratio staff to consumer based on the needs of the consumer. Consumers and representatives were mostly satisfied with the levels of staff providing care.

# 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. | Compliant |

Findings

I am satisfied this Requirement is compliant.

This Requirement was found non-compliant following a Site Audit conducted during 5 October 2021 to 7 October 2021. The service was not able to demonstrate how high impact or high prevalence risks associated with the care of consumers are effectively managed, and how incidents are managed and prevented. The service did not demonstrate how it identifies and responds to abuse and neglect of consumer.

During the Site Audit conducted on 14 December 2022 to 15 December 2022, the Assessment Team found that the service has made changes to more effectively use its electronic recording systems to effectively manage high impact or high prevalence risks associated with the care of consumers, and to manage and prevent incidents.

Management demonstrated the processes that have been introduced, including but not limed to; the use of white board to increase the awareness of high impact and high prevalence risks, clinical staff have been given ownership to identify and make decisions relating to pain management strategies, encouragement to staff to feedback and follow up with clinical staff. All residents with high prevalence risk have been reviewed and strategies and interventions are now in place. The general manager conducts a monthly review of consumers at risk to ensure that strategies and interventions remain current.

The incident management system (IMS) is imbedded in the care management system and informs management that an incident has occurred. Monthly statistical data is extracted and discussions between management, clinical, care and allied health staff occur to create and plan a strategy to reduce the re-occurrence or decrease in the occurrence and likelihood of injury to the consumer. The Assessment Team viewed the SIRS reporting records and noted these were appropriately recorded and reported. Staff had completed training relating to SIRS as part of their mandatory training. Care and Clinical staff were able to describe the processes that they would follow to record incidents of abuse and neglect and confirmed that they had received education.

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)