Performance

Report

**1800 951 822**

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| Name: | Corumbene Hostel |
| Commission ID: | 8024 |
| Address: | 13-23 Lower Road, NEW NORFOLK, Tasmania, 7140 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 7 February 2024 |
| Performance report date: | 6 March 2024 |
| Service included in this assessment: | Provider: 1738 Corumbene Nursing Home for the Aged Inc  Service: 4997 Corumbene Hostel |

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 Corumbene Hostel (**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 (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 acknowledging the assessment team’s report received 29 February 2024.

# 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 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 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

The service was found non-compliant with this requirement at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with consumers confirming satisfaction with care provided consistent with their current needs and preferences. Staff described best practice principles related to incident response and falls management to optimise consumers health and wellbeing. Seven of 7 consumers interviewed expressed their satisfaction with their changing circumstances being identified and assessed in relation to falls incidents and dietary needs.

A review of care file documentation for consumers who experienced falls or choking incidents all reflected effective management, with input from the medical officer, and/or an allied health professional. The Assessment Team noted not all care documentation was complete however, there was no identified impact for consumers and management committed to actions and audits to prevent future recurrence.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 2(3)(e).

# 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. | Compliant |

Findings

The service was found non-compliant with this requirement at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with consumers confirming satisfaction with how falls management care was provided. Staff interviews reflected knowledge and effective management of consumers at high risk of falls.

A review of care file documentation demonstrated effective falls management, with input from the medical officer, and/or an allied health professional. Nursing staff described how falls were considered a high risk at the service and how they have had recent updates to the falls management policy to inform consumer care. They confirmed equipment improvements had occurred, such as bed sensors and replacement of outdated equipment and discussions take place at the falls committee where high-risk consumers are identified. As indicated in Requirement 2(3)(e) the Assessment Team noted not all care documentation was complete however, there was no identified impact for consumers and management committed to actions and audits to prevent future recurrence.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 3(3)(b).

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The service was found non-compliant with this requirement at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with the service now demonstrating assessment and care planning processes include accurate dietary needs and preferences and this information has been communicated to the catering team.

The service has reviewed communication processes to ensure catering staff are receiving timely and accurate information about consumer dietary needs and changes. Nine consumers interviewed confirmed that they are receiving the correct meals that meet their needs including intolerances and allergies. The service has engaged a dietitian to ensure all menu options are meeting the dietary needs and preferences of consumers. The dietician also consults with consumers, in addition to the monthly ‘residents and representative’ forums where the agenda allows consumers to discuss the menus and provide feedback.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 4(3)(d).

# Standard 5

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| 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 |

Findings

Consumers and representatives expressed satisfaction that the service environment was clean, safe and well maintained. Hospitality staff including cleaning and maintenance, demonstrated the services preventative and reactive schedules that ensure the service is clean and well maintained.

The Assessment Team noted that trolleys were not left unattended in corridors and remained in their line of sight of staff as they performed their duties. All cleaning fluids, including chemical agents were marked clearly on bottles and stored in secure locations requiring either a key lock or keypad/fob access.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 5(3)(b).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-compliant with this requirement at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with the service demonstrating feedback and complaints are reviewed, assessed, and recorded in such a way to improve the quality of consumers’ care and services.

The service has initiated the use of an electronic complaint, compliment, and feedback management system to record, triage and assess complaints. The system is accessible all to staff, and management have the ability to review open complaints and raise reports on trending. All open complaints have been reviewed and complaint trend analysis is undertaken monthly and discussed in governance and risk meetings.

There was evidence of feedback and complaints review with resulting actions added to the services Plan for Continuous Improvement (PCI).

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 6(3)(d).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | 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 found non-compliant with requirements 7(3)(d) and 7(3)(e) at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with the service implementing a suite of training, education and supplementary education to support the workforce as well as a formal appraisal process.

Clinical and care staff were satisfied with the training and support they receive. Staff confirmed the online learning platform and computers available in the workplace have allowed staff to access online training in a quiet environment. Training records demonstrated 96% of staff had completed online required training. Management confirmed bespoke face-to-face sessions in response to staff requests and to support consumer care including, consumer dignity and respect, dementia and digital phone refresher have been delivered.

The Assessment Team noted the monthly summary of human resources statistics corporate report, demonstrated that all staff appraisal reviews were up to date. Management confirmed that training needs had been identified through appraisals and valuable feedback provided by staff to support improvement in care resources.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirements 7(3)(d) and 7(3)(e).

# 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e) at a Site Audit from 12 April 2023 to 14 April 2023. Effective actions and improvements have been implemented since that time, with the service:

* developing a sound governance system that includes an effective continuous improvement that includes workforce governance and regulatory compliance,
* an effective process to manage high-impact or high-prevalence risks to consumers in their care, and
* an effective process to manage the required assessments and consents for consumers subject to a restrictive practice.

The service has an embedded process related to continuous improvement to enable identification, monitoring, and review of opportunities for improvement. The service now monitors completion rates for both mandatory staff training and annual performance reviews.

The service has reviewed and updated its restraint management policy and procedure with documents accessible for all staff on an online platform. Management explained that changes in regulatory compliance are reflected in policy and procedures and emailed to staff to advise of changes in addition to toolbox training sessions and at handover meetings.

A ‘falls and management plan’ has been developed to audit and review fall instances, and assessment of those consumers. As a consequence of this analysis the service has developed a checklist to streamline the falls process which is overseen by the quality manager. Falls statistics are monitored by the quality team, including the clinical governance subcommittee, to ensure all assessments, documentation, and follow-up actions are completed correctly.

An audit of all consumers under a restrictive practice was undertaken by the service to ensure that the correct consent documentation was in place and to review consideration of reduction of removal of restraint where appropriate. Behaviour support plans were also reviewed, and consideration given to data collection and trend analysis to improve opportunities for deprescribing the use of restrictive practices. Policies including ‘repeated use of restrictive practice’ and ‘requirements for the use of any restrictive practice’ have been reviewed and updated. The documentation articulates the legislative requirement around obtaining and recording consent and there was evidence of active involvement with medical practitioners to ensure transparency and communication around restrictive practices.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e).

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)