

**Performance Report**

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| Name: | Courtlands Aged Care Facility |
| Commission ID: | 0585 |
| Address: | 15 Gloucester Avenue, NORTH PARRAMATTA, New South Wales, 2151 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 29 October 2024 to 30 October 2024 |
| Performance report date: | 11 December 2024 |
| Service included in this assessment: | Provider: 1008 Christadelphian Homes Limited Service: 5467 Courtlands Aged Care Facility |

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 Courtlands Aged Care Facility (**the service**) has been prepared by G. Harbrow, 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, older people/representatives and others, and
* the provider’s response to the assessment team’s report received 22 November 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **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

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

Requirement 3(3)(a)

• Ensure continuity of consumer care, with consideration given to consumer preference and needs for provision of care that is tailored to the individual consumer and optimises their health and wellbeing. These include but are not limited to; effective pain management with monitoring and evaluation of pain relief strategies for consumers identifying pain, and providing timely personal care assistance tailored to consumers’ needs, which leads to positive consumer experiences.

Requirement 3(3)(b)

• Ensure effective management of high impact or high prevalence risks associated with care of each consumer through clear documentation and evaluation of associated risk management strategies. This includes, but is not limited to, effective management of consumer changed behaviour and associated impacts.

# 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.
 | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

I am satisfied based on the relevant evidence presented in the Assessment Team’s report and the Approved Provider’s response that the service is not compliant with Requirements 3(3)(a), and 3(3)(b), and as a result is not compliant with Standard 3.

Requirement 3(3)(a).

The service was found previously not compliant in relation to Standard 3 Requirement (3)(a), with a subsequent announced Assessment Contact conducted in October 2024.

Not all consumers and representatives were satisfied with the provision of personal and clinical consumer care and the Assessment Team found management of consumer pain and provision of personal care not aligned with best practice.

The service was unable to demonstrate consistency in provision of alternative pain relief strategies or evaluation of the effectiveness of pain relief interventions. Commencement of pain management was not always timely.

The Assessment Team identified staff did not demonstrate person centred care or best practice when a consumer prescribed regular analgesia, was required to wait for an extended period, whilst experiencing pain, before an analgesia was due for administration. Pain management strategies for other consumers were identified as inconsistent, not always effective, or delayed.

The Approved Provider submitted a written response (the response) providing further documentation evidencing pain management and assessment plans for identified consumers had been updated. The response advised the evaluation of regular pain medication as not routinely required with consumers’ medial officers completing a review of consumer medication charts every 3 months. It further identified a review of consumer care needs every 3 months as an opportunity for consumers to identify changes in care needs. The response acknowledged the omission of timely pain charting.

I acknowledge the Approved Provider’s response, and recognise evaluation of effectiveness of regular medications can be acceptable practice when there has been no change is a consumers’ condition, best practice pain management dictates pain monitoring and evaluation of pain intervention strategies whenever a consumer indicates or reports the experiences of pain. Furthermore, a delay of 3 months to identify changes in consumer pain care needs is not acceptable. This, along with the consideration of the impact on individual consumers , I find the service did not demonstrate consumer pain management reflective of best practice, tailored to meet individual consumer needs or to optimise consumer health and wellbeing.

The Assessment Team identified a consumer had made several complaints about the timeliness of staff attendance to assist with toileting. The consumer advised of being told she was required to use a continence aid, due to inconsistent availability of staff assistance. The continence aid was referred to by service staff as a ‘nappy.’ The Assessment Team Report indicated inconsistencies between the consumers preferences and care planning documentation.

At the time of the Assessment Contact, the use of inappropriate terminology by staff was acknowledged by the service management.

The Approved Provider submitted a written response (the response) providing further information to evidence consultation with the consumer’s family confirming the consumer’s use of continence aids with a toileting schedule in place. With the evidence available to me, I am unable to determine if the toileting schedule was being implemented, however I am mindful of the consumer’s preference for assistance with toileting and their making multiple complaints of not being assisted to the toilet on time. I have given weight to the reference of a continence aid as a ‘nappy’ and the associated impact on consumer dignity. As a result, I find the service did not demonstrate best practice care, tailored to consumer needs that optimises consumer emotional health and wellbeing.

The Assessment Team reported inconsistencies in consumer skin integrity management and associated documentation. The Assessment Team determined data reflecting the number of newly acquired pressure injuries by consumers while residing at the service to indicate ineffective skin integrity management.

At the time of the Assessment Contact, inconsistencies in the documentation of consumer repositioning charts were acknowledged and service management advised a quality action initiated in the service’s plan for continuous improvement (PCI), in response. The Assessment Team report does not indicate the nature of the action.

The Approved Provider submitted a written response (the response) providing further information to amend inaccuracies documented in the Assessment Team report. The response advised a consumer identifying with a pressure injury does not have a current pressure injury. The response provided corrective data regarding the number of acquired pressure injuries by consumers at the service. The response advised of benchmarking the service figures against national quality indicators which indicates the service performance aligned with the national average.

The response further expressed concern at the Assessment Team’s findings regarding inconsistencies in documentation associated with the management of skin integrity and advised closed circuit television to confirm the required attendance and associated documentation.

With consideration given to evidence available to me and the Approved Providers response, I am satisfied with the service’s management of consumer skin integrity.

The Assessment Team found medication management did not reflect best practice and while time sensitive medications are administered as scheduled, one consumer did not receive a prescribed medication due to unavailable stock. This omission was not initially identified and documented as an incident.

At the time of the Assessment Contact, service management acknowledged the incident and the oversight of initial identification and incident documentation.

The Approved Provider submitted a written response (the response) providing further information, identifying the omitted medication as administered every 6 months, with administration occurring the following day. The response further identified the incident to provide an opportunity for improvement in relation to stock management.

With consideration given to proportionality and the evidence available to me, I am satisfied with the service’s management of medication administration.

In summary, I find Requirement 3(3)(a) Not-Compliant based on negative consumer experience relating to ineffective pain management, monitoring and evaluation of pain relief interventions, and deficits identified in provision of consumer personal care with associated impact on consumer wellbeing.

Requirement 3(3)(b).

The service was found previously not compliant in relation to Standard 3 Requirement (3)(b), with a subsequent announced Assessment Contact conducted in October 2024.

The Assessment Team found the service did not demonstrate effective management of high impact and or high prevalence risks associated with consumer care relating to falls and changed behaviour.

The service’s management of falls aligned with service policy with appropriate falls risk assessments and documentation. Consumers and representatives were satisfied with the service’s management of falls and subsequent care provision.

With consideration given to proportionality and the evidence available to me, I am satisfied with the service’s management of falls.

The Assessment Team report identified consumers experiencing changed behaviour encountering regular falls, involvement in Serious Incident Response Scheme (SIRS), incidents, and requiring hospital transfers for management of their changed behaviour.

A record of the service’s SIRS incidents indicates consumers experiencing changed behaviour, were involved in several reportable incidents. However, care documentation did not provide strategies to prevent further occurrence.

The Assessment Team report identified deficits in staff charting practices with staff not demonstrating accurate and timely documentation, necessary to provide evidence to evaluate and inform care.

The Assessment Team found consumer behaviour support plans did not provide staff with person centred intervention strategies, with staff trialling a variety of interventions to manage consumer changed behaviour. The trialled interventions were not documented.

At the time of the Assessment Contact, management advised the Assessment Team that consumers’ changed behaviour had been identified as an area of care requiring improvement, with plans for staff education and a review of support services available to consumers living in the dementia specific unit.

The Approved Provider submitted a written response (the response) advising of extensive work completed on consumer behaviour support plans and provided staff attendance records evidencing education provided on supporting consumers living with dementia.

The response advised of family input into strategies for the management of consumer changed behaviour and included updated behaviour support plans for identified consumers which were person centred and included detailed strategies for management.

The response advised that care needs for consumers identified as at risk associated with changes in behaviour, are communicated verbally to staff at a variety of staff forums. The response further advised for consumers new to the service, verbal reports and handovers are used to inform interim care plans.

I acknowledge the Approved Provider is actively engaging activities to improve the management of high impact and high prevalence risks, however, I am mindful of inconsistencies in documentation and a reliance on verbal communication to identify and share the risk management strategies for consumers experiencing changed behaviour.

Verbal communication does not effectively demonstrate the ongoing assessment of risk assessment to inform effective person centred care planning and management strategies. Subsequently, the service has not demonstrated consistency in the documentation and evaluation of strategies to manage risks associated with consumer changed behaviour.

Further to this, the service is not demonstrating effective risk management with consideration for the safety of consumers experiencing changed behaviours, impacted consumers and staff.

With consideration to the available evidence including the Approved Provider’s response, I find Requirement 3(3)(b) Not-Compliant.

# Standard 8

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| Organisational governance |  |
| 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 previously not compliant in relation to Standard 8 Requirement (3)(e), with a subsequent announced Assessment Contact conducted in October 2024.

The Assessment Team report identified the introduction of a revised clinical governance framework May 2024, which includes the organisation’s management roles and responsibilities. Policies and procedures in relation to antimicrobial stewardship (AMS), minimising the use of restraint, and open disclosure are current.

The Assessment Team identified systems and processes for collecting, analysing, and reporting on clinical performance to the governing body, however, determined the information reported to be insufficient for informed decision making.

The Assessment Team found the organisation demonstrated the identification and actioning of continuous improvements activities regarding additional resources to support clinical governance and education of staff. However, the service’s plan for continuous improvement (PCI) was deemed incomplete with recent areas for improvement not included and some action items overdue.

The Assessment Team report identified a new clinical leadership team in the process of embedding new practices. Education is ongoing, however is yet to be evaluated for effectiveness.

The Approved Provider submitted a written response (the response) providing further information and evidence including policies, meeting minutes, reports, and agendas, which I have reviewed in detail. The documents demonstrate responsibilities and lines of reporting to provide oversight of clinical care, including but not limited to, those related to AMS, minimising the use of restrictive practices and the practice of open disclosure. The organisation demonstrated systems to monitor and improve care and service delivery with identification of opportunities for continuous improvement. The response included the service’s PCI, which reflects recently identified areas for improvement.

The Assessment Team recommended this Requirement as not-met. However, with consideration to the information available to me including Approved Provider’s response, I have come to a different view to the Assessment Team’s recommendations and I find Requirement 8(3)(e) 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)