Performance

Report

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| Name: | Della Dale Aged Care |
| Commission ID: | 4190 |
| Address: | 17 Derwent Street, RINGWOOD NORTH, Victoria, 3134 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 14 August 2024 |
| Performance report date: | 16 September 2024 |
| Service included in this assessment: | Provider: 918 NDN Care Services Pty Ltd  Service: 2734 Della Dale Aged Care |

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 Della Dale Aged Care (**the service**) has been prepared by Micheal Cooper, 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 to the assessment team’s report received 6 September 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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 2(3)(a)** – The approved provider must implement an effective assessment and planning process which considers and responds to risks to the consumer’s health and well-being to inform delivery of safe and effective care and services. Specifically, risks associated with the assessment, management and ongoing monitoring of consumer’s subject to restrictive practice to ensure that the practice or intervention is necessary and proportionate to the risk of harm, and guide staff to effectively support the consumer to ensure their needs and preferences are consistently and appropriately met.
* **Requirement 7(3)(d)** – The approved provider must implement effective systems to ensure the workforce is recruited, trained, and are equipped to meet the needs of each consumer.
* **Requirement 8(3)(c) –** The approved provider ensures the organisation's information management system is effective, and review of incidents, complaints and clinical data is conducted to inform required improvement actions to ensure safe and quality care and service are provided to consumers.

# 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. | Not Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |

Findings

The assessment contact report contains information that identifies consumers sampled are subject to restrictive practice(s), particularly chemical and/or physical restraint without appropriate assessment, monitoring and review. The sampled consumers’ assessment and planning documentation does not demonstrate ongoing assessment to ensure the consideration of risk(s) and the assessed need for a restrictive practice is in proportion to the risk of harm to the consumer and/or others.

The approved provider’s response submission included:

* Documentation for several consumers were reviewed in relation to the use of restrictive practices. The provider’s response outlines that informed consent has now been recorded for several consumers. However, the documentation did not demonstrate a valid informed consent process has occurred and appropriately recorded by an appropriate approved health practitioner in accordance with the Principles. This includes a description of the consultation about the use of the restrictive practice with the consumer or restrictive practices substitute decision maker (if the consumer lacks capacity). Nor did the documentation evidence a record of the giving of informed consent for the use of the restrictive practice, and how it is to be used (including the duration, risks and benefits, frequency and intended outcome).
* Clinical notes for a named consumer identified the use of physical restraint and chemical restraint in place. However, there is limited evidence the service has assessed the use of the restrictive practice is necessary, as a last resort and that staff are implementing best practice alternative strategies prior or considering and monitoring impact to the consumers’ health and/or wellbeing.

In coming to my decision for Requirement 2(3)(a), I have considered the information provided in the assessment contact report and approved provider’s response. I acknowledge the actions the approved provider has taken and plans to take to remediate the deficiencies identified, however I am of the view that the actions being taken by the service will take some time to be fully implemented and evaluated for effectiveness. I have placed weight on care documentation provided demonstrating where restrictive practice is used it is not always used as a last resort and in proportion to the risk of harm. Best practice alternative strategies are not always documented to guide staff in the care of individual consumers, and consideration of associated risks are not always evaluated or recorded. The service was unable to demonstrate assessment and care planning includes the consideration of risks to consumers’ health and wellbeing.

It is my decision Requirement 2(3)(a) is Not Compliant.

Consumers and representatives provided positive feedback in relation to how the service demonstrates ongoing partnership and explained they are involved in assessment and planning. Service documentation demonstrated quarterly care plan reviews have occurred in consultation with consumers and representatives. Staff explained and service documentation demonstrated the service conducts quarterly assessment and planning consultations with consumers and their representatives and when care needs change. Service documentation demonstrated the involvement of medical and allied health professionals when care needs change or when care planning is reviewed.

In coming to my decision for Requirement 2(3)(c), I have considered the information provided in the assessment contact report and I have placed weight on positive feedback provided by consumers and representatives and documentation evidencing ongoing partnership with those who are involved in care provided or received.

It is my decision Requirement 2(3)(c) is Compliant.

# 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. | Not 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’s education register evidenced several staff who had not completed all mandatory education. Service documentation demonstrated training had not been provided to staff in relation to the Quality Standards, antimicrobial stewardship, and open disclosure. Several staff could not demonstrate an understanding of processes relating to the serious incident response scheme (SIRS) and restrictive practice management. One staff member explained they had not received training in relation to the Quality Standards nor had they received any form of education or training in 2024.

In response to the deficiencies identified, the approved provider accepted training has not been provided in relation to the Quality Standards and the service plans to incorporate Quality Standards training in their education matrix. The approved provider’s response indicates training in relation to open disclosure has been provided in 2023, however did not provide evidence of the education material used, nor was evidence provided to inform if the entire workforce attended the education session. The approved provider submitted documentation demonstrating education has been provided in relation to antimicrobial stewardship, however, did not evidence if the entire workforce attended the education session.

In coming to my decision for Requirement 7(3)(d), I have considered the information provided in the assessment contact report and the approved provider’s response. I acknowledge the approved provider’s planned actions to remediate the deficiencies identified, however, I have placed weight on feedback provided by staff and the knowledge deficits identified among sampled staff, including a lack of understanding of associated processes in relation to SIRS and restrictive practice management. Additionally, service documentation evidenced the workforce is not always trained and equipped to deliver outcomes required by the Quality Standards.

It is my decision Requirement 7(3)(d) is Not Compliant.

Service documentation demonstrated yearly performance appraisals have been conducted for the period of 2022 to 2023 with planned appraisals to occur in 2024. Staff confirmed they have been involved in individual performance appraisals. Management explained they monitor staff performance and identify areas for improvement when directly working with staff through day-to-day tasks and duties. Service documentation demonstrated management is identifying areas for performance improvement and actions are recorded, reviewed and implemented for further monitoring to enhance staff performance.

In coming to my decision for Requirement 7(3(e), I have considered the information in the assessment contact report and I have placed weight on feedback provided by staff and service documentation evidencing monitoring and review processes of staff performance.

It is my decision Requirement 7(3)(e) is 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. | Not Compliant |

Findings

Information contained in the Assessment Contact report under this and other requirements demonstrated the organisation does not have effective governance systems in relation to information management, continuous improvement and workforce governance.

In relation to information management, information in the Assessment Contact report identified that while staff had access to the service’s electronic care management system, assessment and care planning information (and associated documentation such as handover documentation) did not consistently reflect accurate information to guide and inform the delivery of personal and clinical care or to support the monitoring of care delivery. For example, one named consumer’s care information was updated on the service’s handover document which staff utilise to inform care requirements for each consumer, however information was not updated in the consumer’s care plan resulting in clinical information not accurately being reported on both information platforms. As considered under my decision for Requirement 2(3)(a), information in relation to the assessment and care planning for consumers is inconsistent with processes to effectively determine when a practice or intervention used as part of a consumer’s care is a restrictive practice.

In relation to continuous improvement, the organisation’s systems and processes did not demonstrate at the service level the analysis of incidents, complaints, or clinical data to determine ongoing improvements actions. In the response submission, the approved provider advised future analysis is planned to be undertaken. I have considered in my decision, the service continues to be non-compliant with the Quality Standards in relation to consumer assessment and care planning, human resources and organisational systems.

In relation to workforce governance, the service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards specifically in staff completion of mandatory training and onboarding of labour hire staff. The approved provider was in agreement with these findings and advised an update to the education matrix to require all staff, including labour hire, to attend and complete all mandatory training set by the organisation.

In coming to my decision for Requirement 8(3)(c), I have considered the information contained in the assessment contact report under this and other Requirements, and I acknowledge the actions planned by the service to address the deficiencies identified. I am of the view that the actions being taken by the service will take some time to be fully implemented and evaluated for effectiveness.

It is my decision, Requirement 8(3)(c) is Not Compliant.

1. The preparation of the performance report is in accordance with section s 68A – assessment contact, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)