

**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 21 November 2024 |
| Performance report date: | 19 December 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 R Beaman, 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, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumer/representatives and others;
* the provider’s response to the Assessment Team’s report received 13 December 2024; and
* the performance assessment report dated 16 September 2024 for an assessment contact undertaken on 14 August 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **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

**Standard 2 requirement (3)(a)**

* Ensure assessment and planning include consideration of risks to consumer health and wellbeing to inform safe and effective care, including risks associated with behaviour, pain management and restrictive practices.

**Standard 3 requirement (3)(b)**

* Ensure high impact or high prevalence risks associated with the care of each consumer are managed effectively, including behaviours and restrictive practices.

**Standard 7 requirement (3)(d)**

* Ensure the workforce are trained, equipped and supported to deliver the outcomes requirement by the Quality Standards.

**Standard 8 requirement (3)(c)**

* Ensure there are effective organisational governance systems and processes in place, including, but not limited to, information management, continuous improvement, workforce governance, feedback and complaints and regulatory compliance.

# 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 |

Findings

Requirement (3)(a) was found non-compliant following an assessment contact in August 2024 as assessment and planning was not undertaken with consideration of risks to consumers’ health and wellbeing, specifically in relation to restrictive practices.

At this assessment contact, the Assessment Team’s report noted a range of improvements had been proposed and partially implemented in relation to the deficits identified. However, the Assessment Team recommended this requirement as not met as they were not satisfied assessment and planning considered risks to consumers’ health and wellbeing to inform safe and effective care delivery, specifically in relation to behaviour and pain management and use of restrictive practices.

The Assessment Team’s report included the following information gathered via documentation review, interviews, and observations relevant to my finding:

* One consumer who entered the service during November 2024 did not have a care plan in place to guide staff. The consumer has a significant medical condition that includes a high risk of falls, and assessments completed for nutrition and mobility did not include mitigation strategies to manage the risks identified. Staff did not have a care plan with actions to guide delivery of safe care to the consumer.
* The consumer was reviewed by the physiotherapist after admission who identified high falls risk and pain. No assessments were undertaken in relation to mobility or pain for this consumer and strategies to guide delivery of care that considered risks in relation to falls and pain were not available for staff.
* Management acknowledge assessments had not been completed for the consumer for the 2 weeks prior to the assessment contact when the consumer entered the service.
* Four consumers who experience changed behaviours, did not have effective assessments in relation to behaviour management completed to determine effective mitigation strategies to manage adverse behaviour. While 3 of the 4 consumers had a restrictive practice in place, there was no clear guidance for staff around monitoring of the restraint when applied. No assessments have been undertaken to develop mitigation strategies to guide staff in managing consumers’ changed behaviours.
* Management confirmed they do not use assessment charting to monitor and evaluate risks to consumers, including changed behaviours and pain, and said they use progress notes to inform consumer care.
* One of the consumers has physical restraint applied during delivery of personal care which includes staff holding the consumer’s upper and lower limbs down to prevent them from hitting or kicking staff. Progress notes indicated in a 2-week period during November 2024, physical restraint was used on 2 occasions, however, care planning documentation recorded no changed behaviours displayed. Mitigation strategies for the consumer are generic and not personalised, and do not outline how to mitigate risk of harm. A safe environment assessment completed in November 2024 included generic strategies to mitigate risks, such as pressure injuries, wounds, falls and social isolation.

The provider did not agree with the Assessment Team’s recommendations and included additional commentary and information in their response. In relation to assessments not being completed for consumers in relation to pain and behaviour, the provider asserts the service have clinical staff in dedicated documentation roles, including service management who complete all assessments and care plans. The provider asserts 2 members were on leave, and in relation to the consumer who entered the service in early November 2024, the provider asserts this was the reason for no assessments completed. The provider also asserts for this consumer, the physiotherapist review was considered as an assessment completed. The provider also asserts for this consumer, nurses administering pain relief to the consumer on specific days in November 2024 constitutes staff are assessing the consumer’s pain.

In relation to assessment and planning, including for pain and falls, the provider asserts these are all completed on admission and included additional information, including care plan and assessments for the named consumers.

I acknowledge the additional information and commentary included in the provider’s response; however, I find assessment and planning is not undertaken with the consideration of risks to consumers’ health and wellbeing to inform delivery of safe and effective care. In coming to my finding, I have considered information in the Assessment Team’s report that shows for one consumer with a significant health condition that includes a high falls risk, planning and assessment was not done in in line with the service’s own policy, and assessment for pain, falls and behaviour was not undertaken in a timely manner to identify strategies to mitigate those risks. For this consumer, I have considered information in the provider’s response that shows assessments for behaviour and restrictive practices are in place, however, I do not find those to be individualised and information is broad and does not identify the consumer’s specific things of interest or actions that will either trigger or guide staff in managing the behaviour prior to a restrictive practice being considered. For this consumer, I have also considered information included in the provider’s response, including the restrictive practices care plan which shows they were completed subsequent to the assessment contact visit. I acknowledge the provider’s assertion in relation to pain that includes nurses administered pain relief on several occasions in late November 2024 as evidence they monitor and assess for pain, however, I have no evidence before me that shows the assessment of pain completed to make the decision to administer pain relief or the evaluation that it is effective and I have taken into consideration and place weight on feedback provided by management during the assessment contact that includes they do not use consumer charting information to assess, monitor or evaluate care.

In relation to behaviour management and use of restrictive practices, I acknowledge the provider’s assertion consents are obtained from both the prescriber and substitute decision maker, however, information included in the response for 2 consumers shows this consent is from the prescriber which does not satisfy me the risks associated with restrictive practices, specifically chemical and physical restraint have been discussed with the consumer or their decision maker to be considered as part of their care planning.

In relation to the consumer who has a restrictive practice in place where staff provided information about strategies that work for the consumer, I have considered the information in the Assessment Team’s report that shows those strategies are not documented to guide all staff in managing the consumer’s changed behaviour, and I have not been provided evidence to show these have been included or the consumer care plan updated.

I acknowledge actions the provider has taken or is planning to take included on the plan for continuous improvement, however, find these will need more time to be fully embedded to determine if they are effective and sustainable to achieve improvements in the care delivery, as well as assessment and planning.

For the reasons above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

# 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. | Not Compliant |

Findings

Quality Standard 3 is non-compliant as the requirement assessed has been found non-compliant.

The Assessment Team recommended requirement (3)(b) not met as they were not satisfied high impact or high prevalence risks associated with consumer care were effectively managed, specifically in relation to behaviour, pain, weight loss and restrictive practices. The Assessment Team’s report included the following information and evidence gathered through interviews, documentation and observations relevant to my finding:

* One consumer identified with changed behaviours has a restrictive practice in place that is not monitored or applied as a last resort. Staff confirmed they apply physical restraint by holding the consumer’s limbs when they are physically aggressive during personal care. Some staff described an alternative strategy of providing the consumer a rolled-up towel, but this was not documented to guide all staff delivering care.
* The consumer was also identified with weight loss of 5kg between July 2024 and November 2024 with the most recent nutrition assessment in November 2024 recording a very high risk of malnutrition. The assessment also included strategies to monitor and manage the consumer’s weight loss, such as recording dietary intake, weekly weights, dietary supplements and liaising with the medical officer and dietitian. Documentation did not show interventions were consistently actioned, including regular weights or referral to dietitian. The service did not have documented processes to guide staff to ensure weight loss was monitored and managed.
* Another consumer did not have effective pain or behaviour management in place. The consumer was observed wandering throughout the assessment contact visit with no staff interaction or assistance and post the lunch service was observed grimacing and calling out loudly without staff intervention or strategies trialled. Documentation in the week prior showed the consumer was experiencing increased pain in their right leg as they were recorded as limping and agitated, but did not include any monitoring of this or behaviour, including charting. The consumer was administered a psychotropic medication in an as required dose to manage their behaviour. Staff recorded the medication was administered for their behaviour and had tried other strategies.
* Management confirmed they advised staff to administer as required psychotropic medication with analgesia as the consumer’s changed behaviour had escalated. Management confirmed they did not have a monitoring chart or process in place to ensure changed behaviours and pain are monitored.

The provider did not agree with all the findings in the Assessment Team’s report and included additional information and commentary in their response in relation to both consumers. In relation to weight loss, the provider’s response includes the service’s nutrition and hydration policy and procedure which includes a dietician review should occur when required, including when weight loss occurs or the supplement regime not working. The provider also asserts the service has investigated multiple underlying conditions to manage ongoing weight loss for the consumer, and additional commentary, including a further weight loss in December 2024 and the consumer will be referred to the dietitian for review.

In relation to the consumer administered psychotropic medication for behaviour management, the provider asserts staff were consistently interacting with the consumer indoors during the assessment contact and prior to administration of as required psychotropic medications in November 2024. The provider asserts staff trialled multiple strategies to manage the consumer’s agitation and the decision was then made to administer the medications.

I acknowledge the information included in the provider’s response; however, I find high impact or high prevalence risks associated with consumers’ care, specifically behaviour and pain management and use of restrictive practices is not effectively managed. In coming to my finding, I have considered information in the Assessment Team’s report that shows for the consumer who was subject to chemical restraint and administered psychotropic medication, the use of this restrictive practice was not monitored effectively. I acknowledge the assertion the provider made in their response in relation to all interventions occurring indoors, and have placed weight on commentary in the provider’s response that includes it is not common practice to monitor the consumer once the chemical restraint has been administered when it is a half dose as staff know how the consumer reacts with the medication. However, the application of restrictive practices is required to be continually monitored of which for this consumer it is not, and staff are not accurately capturing evaluation post administration or effectiveness.

Further, I have considered information in the provider’s response in relation to requirement (3)(a) in Standard 2 which shows chemical restraint was not monitored or used as a last resort when the consumer displayed agitation. I have placed weight on the information included in the provider’s response for this consumer which shows staff made the decision to apply chemical restraint without recording strategies trialled, to show this was a last resort, or that pain was considered when the consumer was observed to be limping for the week prior. For this consumer, the provider asserts there has been no administration of as required anti-psychotic medication, however, included evidence to show this occurred in November 2024 after the assessment contact visit and I have no evidence before me that shows this was done as last resort, monitored or reviewed.

In relation to use of physical restraint for one consumer, I have considered information in the Assessment Team’s report that shows the use of physical restraint is not documented or recorded and staff do not show this is used as a last resort. I have also considered information in the provider’s response that includes an assumption that staff know what agitation means for this or specific consumers. However, the application of restrictive practices is required to be a last resort, and monitored and reviewed, and I am not persuaded this occurs and find this is a systemic issue. I acknowledge the provider has included additional text in the consumer’s behaviour support plan, however, this has been done subsequent to the assessment contact visit and I find it will need more time for those to be embedded and for evaluation of the changes made.

For the reasons above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-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 |

Findings

Requirement (3)(d) was found non-compliant following an assessment contact in August 2024 as an effective system to ensure the workforce was recruited, trained and equipped to meet the needs of consumers was not demonstrated.

At this assessment contact, the Assessment Team’s report noted improvement actions underway to address the deficits identified, including, but not limited to, engagement of an external offsite consultant, a review of policies and procedures related to non-compliance, and the purchase of a new electronic training system. However, the Assessment Team recommended this requirement as not met, as they were not satisfied the service has systems in place to ensure the workforce is trained and equipped to deliver quality care and services.

The Assessment Team’s report included the following information and evidence gathered through interviews and documentation relevant to my finding.

* Management confirmed they had identified 6 modules for staff to undertake as a priority in relation to the previous non-compliance.
* Management described how they have focused training on regular staff and the expectation of agency staff is training is completed within their own agency. Documentation showed only 55% of staff had completed the priority modules.
* Staff confirmed they had received information from management in relation to a new electronic training system.
* Management confirmed the service has engaged an external consultant to review and implement related policies and described how audits can monitor and influence training needs and delivery.

The provider did not agree with the Assessment Team’s recommendations and included additional information and further commentary in their response. Improvement actions include, but are not limited to, implementation of an electronic training system and incentives for staff to complete in a timely manner and implementing an ongoing training calendar. The provider asserts as they have demonstrated the service meets the requirements in Standards 2 and 3 and there are no deficits in the training provided.

I acknowledge the information and additional commentary in the provider’s response. However, I find an effective process to ensure staff are trained, equipped and supported to deliver the outcomes requirement by the Quality Standards was not demonstrated. In coming to my finding, I have considered information in Standards 2 and 3 that shows deficits in staff practice in relation to management of consumers with changed behaviours, pain and the use of restrictive practices. I have also considered information in the provider’s response in requirement (3)(b) Standard 3 that shows restrictive practices, specifically chemical and physical are not used as a last resort and staff are not monitoring the use or the effectiveness of those. Further, information in Standards 2 and 3 demonstrate deficits in assessment and planning and management of high impact high prevalence risks, specifically behaviour management and use of restrictive practices are systemic and I have no evidence before me that shows staff have been specifically trained in the areas in relation to the deficits identified.

I acknowledge the improvement actions the provider has taken or planning to take, however, as the training actions are not expected to be completed until next year, I find these will need time to be embedded and achieve efficacy.

For the reasons above, I find requirement (3)(d) in Standard 7 Human resources non-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**

Requirement (3)(c) was found non-compliant following an assessment contact in August 2024 as effective organisational governance systems in relation to information management, continuous improvements and workforce governance were not demonstrated.

At this assessment contact, the Assessment Team’s report noted a range of improvements had been proposed and partially implemented in relation to the deficits identified, including engagement of an external consultant to review policies and procedures relating to the non-compliance. However, the Assessment Team recommended this requirement as not met as they were not satisfied the organisations governance systems were effective in relation to information management, continuous improvement, workforce governance, management of feedback and complaints and regulatory compliance.

The Assessment Team’s report included the following information and evidence gathered through interviews and documentation relevant to my finding:

* Documentation used by staff to guide practice did not contain information to ensure care is safe and effective. Care documentation did not include strategies to guide staff to deliver care, specifically in relation to behaviour management, use of restrictive practices or for new consumers.
* Management confirmed clinical staff have restricted access to the electronic care system, and monitoring mechanisms, such as charting are inactive as they monitor progress notes to inform care delivery.
* The service’s plan for continuous improvement only includes actions from previous non-compliance.
* Training is not effective in ensuring staff are equipped to deliver care and services in safe and quality manner, specifically in relation to behaviour management and use of restrictive practices.
* Management confirmed a planned action is to include competency based training for staff and have priority modules for staff to complete.
* The service does not have an effective process or oversight to ensure restrictive practices, informed consent and behaviour support plans are completed in line with regulatory requirement.
* The psychotropic register only included medication that was considered a chemical restraint. Informed consent forms did not evidence consultation had occurred with the consumer or substitute decision maker.
* Management confirmed regular resident/relative meetings are not scheduled and there is no consumer advisory group in place at the service.
* The service does not have an effective feedback and complaints system in place, and feedback is not evaluated to drive improvements in care and services.

The provider did not agree with all findings in the Assessment Team’s report and included additional information and commentary in their response. The provider asserts care documentation caters to the needs of the cohort of consumers and staff have access to those along with policies and procedures to guide practice. In relation to continuous improvement, the provider asserts the service has a plan for continuous improvement that is more expansive than the improvement actions for the non-compliance. The provider included additional information in their response which shows staff training is scheduled for December 2024 in relation to care delivery. In relation to regulatory compliance, the provider included additional information around the restrictive practice policy and asserts informed consent forms are completed with the prescriber.

I acknowledge the additional information and commentary in the provider’s response, including the assertions made around the deficits identified, however, I find an effective organisational governance system was not demonstrated. In coming to my finding, I have considered information in other areas of the Assessment Team’s report that shows care documentation does not support staff to deliver care and services consistently, including, but not limited to, information to guide staff managing consumers with changed behaviours, and use of restrictive practices. Further, there is no formal process to monitor those as the provider asserts staff know consumers well and for the consumer administered psychotropic medications to manage behaviours staff are aware how they react to medication. In relation to continuous improvement, I acknowledge the provider’s assertion they have an additional improvement plan in place and the documentation included in their response, however, I find the actions are not improvement actions that are consumer focused.

In relation to workforce governance, I have considered information in the Assessment Team’s report that shows the workforce is not effectively trained, and place weight on deficits identified in relation to use of restrictive practices and behaviour management. I acknowledge the actions the provider has already implemented and is planning to take for staff training and the oversight of that, however, find this will need time to be further embedded to achieve efficacy.

In relation to regulatory compliance, I acknowledge additional information from the provider in relation to restrictive practices, including review of the restrictive practices policy and review of consent forms. However, information in Standards 2 and 3 of this report show restrictive practices are not consistently applied as a last resort and, where chemical restraint is used as a strategy to manage behaviours, this is not monitored or evaluated for effectiveness. Whilst the provider asserts staff know consumers well and know the named consumer has no adverse reaction, this does not demonstrate an effective governance system of oversight for restrictive practices. Further, the provider’s response shows there are currently no clear processes in place to ensure governance and oversight to enable areas of concern to be identified and addressed. I acknowledge governance meetings and reporting is an action the provider is currently working towards implementing; however, I find this will need time to be fully embedded.

For the reasons above, I find requirement (3)(c) in Standard 8 Organisational governance non-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)