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: | 5 September 2023 to 6 September 2023 |
| Performance report date: | 26 October 2023 |
| 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 S Byers, 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 5 October 2023 and 24 October 2023.
* the assessment team’s report for the Monitoring assessment contact 31 May 2023
* other information and intelligence held by the Commission

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **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 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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) – develop and implement an effective system and process to ensure assessment and planning considers risk to consumers health and well-being and informs the delivery of safe and effective care and services, ensure documentation is consistent and accurate and staff understand the assessment and planning documentation processes.
* Requirement 2(3)(c) - develop and implement an effective system and process to ensure assessment, planning and review is based on regular and ongoing partnership with consumers and representatives.
* Requirement 7(3)(d) – develop and implement an effective system and process to ensure the workforce is recruited, trained, equipped and supported to deliver outcomes under these Quality Standards
* Requirement 7(3)(e) - develop and implement an effective system and process to ensure each member of the workforce is regularly assessed, monitored and reviewed.
* Requirement 8(3)(c) – ensure effective organisation-wide governance systems are in place relating to information management, continuous improvement, feedback and complaints and workforce governance.

# 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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirements 2(3)(a) and 2(3)(c) are non-compliant:

Requirement 2(3)(a)

The Assessment Team found that while some consumer care documents considered risk, all care files reviewed contained inconsistent and inaccurate assessment and planning information to inform care and delivery. Staff described risks consistent with consumer documents, however described needs, preferences, and interventions inconsistent with those documented. For new consumers, assessment and care planning documents were incomplete or included limited information to inform care delivery. Staff described the assessment and planning process for permanent consumers, however, advised there was not a process in place for respite consumers. Consumers and representatives confirmed participating in pre-admission and initial assessment and planning discussions and said they are consulted about risk when incidents occur or needs change, however, not on a regular or ongoing basis.

I have considered information under requirements 3(3)(a) and 3(3)(b) in relation to documentation deficits under this requirement.

The approved provider submitted a written response with clarifying information and documentation including handover notes for a named consumer. The provider submitted a Plan for Continuous Improvement (PCI) demonstrating the actions planned to address the areas of improvement. Actions include review of processes including monthly care reviews, review and update of care plans, review and amend policies and procedures, and the development of an admission process.

The provider agrees with the findings in the assessment team report that documentation is inconsistent at the care plan level, however, asserted that the day-to-day handover document and process is comprehensive. The provider submitted that staff do not have time to read care plans to inform care delivery, and the provider decided to focus on the daily handover process rather than care plans to inform care delivery. The provider did not provide any supporting evidence in relation to the handover process; therefore, I do not have sufficient evidence to demonstrate a robust handover process is in place.

In the response, the provider explained that due to the small standalone structure of the service, they take on multiple responsibilities including Clinical Care Coordinator and Director of Nursing and it is their responsibility to ensure assessments and care plans are up to date and accurate. In relation to improvement actions, the provider has submitted they will take on the monthly review of consumer documentation, in addition to other responsibilities. The provider has not submitted evidence to demonstrate how this will be sustained in practice. The response also highlights the provider has identified gaps in the services document system and processes, and staff understanding and application of those processes.

I have reviewed the evidence in the assessment team report and the providers response. While I acknowledge the remedial actions planned by the provider in response to the assessment team report, it will take some time to fully implement and evaluate the effectiveness and sustainability of the actions. I am not satisfied the provider’s response demonstrated that an effective system is in place, or the provider has sufficient capacity to effectively implement, manage and sustain improvements to ensure assessment and planning considers risk to the consumers health and well-being, and is accurately and consistently documented to inform the delivery of safe and effective care. I find requirement 2(3)(a) is non-compliant.

Requirement 2(3)(c)

All consumers and representatives said they are not involved in the assessment, planning and review of consumer care and services, and do not feel that monthly care reviews are based on ongoing partnership. Management and clinical staff said consultation with consumers and representatives occurs following incidents or a change in circumstances, however staff do not partner with consumers or representatives during monthly care reviews. Care documents recorded reviews take place without consultation or discussion with consumers or representatives about care and services. Staff said that in the absence of staff meetings and ongoing partnership with consumers and representatives the opportunity to provide feedback to inform care delivery and supports is limited.

The approved provider submitted a written response with clarifying information. The provider submitted that since COVID-19, meetings were replaced by an electronic messaging (WhatsApp) group to continue communication with consumers and representatives, however, acknowledges that this method of communication has not been effective due to diverse levels of IT literacy and limited structure. The provider submitted a Plan for Continuous Improvement (PCI) demonstrating the actions planned to address the areas of improvement. Actions include re-establishing consumer and relative meetings, care plan reviews and monthly care consultations with consumers and representatives. Conflicting information was provided in relation to care consultations, the response states an intention to review monthly care consultations, however the PCI indicates an intention to reduce care consultation to quarterly. I do not have sufficient evidence to demonstrate an effective plan or system is in place to support ongoing partnership.

I am satisfied the service has demonstrated it has systems in place to partner with other organisations, individuals and providers of care. Care documents detailed coordinated assessment and planning with medical practitioners, specialists and allied health professionals.

I have reviewed the evidence in the assessment team report and the providers response. While I acknowledge the remedial actions planned by the provider in response to the assessment team report, it will take some time to fully implement and evaluate the effectiveness and sustainability of these actions. I have also placed weight on the feedback provided by consumers and representatives who were not satisfied the service partners with them, and staff feedback that confirmed partnership is not occurring in practice. While I am satisfied assessment and planning includes other organisations, individuals and providers of care, I am not satisfied the provider has demonstrated effective systems and process are in place to ensure ongoing partnership with consumers and their representatives. I find requirement 2(3)(c) is non-compliant.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Consumers and representatives were satisfied consumers receive care that is safe and right for them, providing positive feedback in relation to the management of pain, wounds and restrictive practices. Staff provided examples of how they tailor personal and clinical care to optimise consumer’s needs, goals, and preferences. Care documentation detailed individual pain management strategies, wound healing and pressure relieving strategies. The service is a secured facility, and all consumers are recognised as subject to environmental restraint. While inconsistencies were identified in consent documentation, consumers and representatives confirmed providing informed consent and were satisfied with the management of chemical and environmental restraint. Care and clinical staff described consumers restrictive practices in accordance with care documentation and information provided by consumers and representatives. The organisation demonstrated it has policies and procedures in place to guide staff practice.

Consumers and representatives were satisfied the service is effectively managing high-impact and high-prevalence risks. Management and staff described the high-impact and high-prevalence risks for consumers at the service. Consumer care planning documentation demonstrated a multidisciplinary approach to the management of risks relating to weight loss, falls and diabetes. Falls documentation demonstrated post fall assessment including neurological observations.

I have considered information under requirements 3(3)(a) and 3(3)(b) in relation to documentation deficits under requirement 2(3)(a).

Based on the evidence, as summarised above, I find requirements 3(3)(a) and 3(3)(b) are compliant.

# 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 |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Consumers and representatives were satisfied with the services and supports for daily living provided by the service and described how they are supported to engage in their preferred activities. Consumers and representatives said they can provide feedback about supports and services and are supported by volunteers to engage in activities of their choice. While there is currently no specific lifestyle staff at the service, regular and agency staff demonstrated knowledge and understanding of individual consumer needs, goals and preferences in line with information provided by consumers. Consumers were observed engaged in preferred supports of daily living and activities during the assessment contact.

Consumers and representatives said meals are of suitable quality and quantity, with a variety of options available including alternatives to the set menu. Staff demonstrated understanding of individual consumer preferences and dietary requirements including texture modified meals. Care planning documents and noticeboards in the kitchen reflected information relating to specific dietary needs, dislikes, allergies, and preferences. The service demonstrated the seasonal menu is developed and reviewed by a dietitian. The service has processes in place to support consumers to provide input into the menu and feedback about the meals through direct discussions with staff and management. The Assessment Team observed the dining room was well attended by the consumers during the lunch service and there was a social atmosphere. Staff were observed assisting consumers with their meals in a respectful unhurried manner, and consumers received their meal of choice. Consumers who prefer to dine in their rooms were observed to have received their meals in a timely manner, with staff providing support, where required.

Based on the evidence, as summarised above, I find requirements 4(3)(a) and 4(3)(f) are compliant.

# 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 were satisfied the service environment is safe, homely, and comfortable. Consumers said they can move freely throughout the service. While some internal courtyard doors were locked, management described how consumers freely access external areas, gardens and courtyards with support of staff. The service is a secured facility, and all consumers are recognised as subject to environmental restraint. Consumers and representatives were satisfied with the secured facility arrangement and confirmed environmental restraint had been discussed with them. Staff demonstrated understanding of cleaning and maintenance processes, and cleaning and maintenance schedules were in place. Maintenance records reflected all maintenance requests were completed within a timely manner. The indoor service environment was observed to be clean with uncluttered corridors, and outdoor areas included well-maintained walking paths.

Based on the evidence, as summarised above, I find requirement 5(3)(b) is compliant.

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirements 7(3)(d) and 7(3)(e) are non-compliant:

The service was found non-compliant in Standard 7 in relation to requirement 7(3)(e) following a site audit in November 2022 where it was unable to demonstrate the performance of the workforce is regularly assessed, monitored and reviewed and annual performance reviews were completed for each member of the workforce.

Requirement 7(3)(e)

At the September 2023 assessment contact the Assessment Team identified ongoing deficits in the service’s assessment, monitoring and review of the workforce. The deficits relating to the review of workforce performance were first identified at a November 2022 site audit where the service was found non-compliant with this requirement. The service did not demonstrate progress had been made to rectify the deficits at a monitoring visit in May 2023. At the September 2023 assessment contact, the service demonstrated policies and processes to formally monitor and review workforce performance had been developed, however the service did not demonstrate these policies were implemented in practice. All staff interviewed said they had not participated in a performance review in the last 2 years. Performance review records demonstrated a small number of performance reviews had been completed for the 2022 year and no performance reviews completed for the 2023 year. Management confirmed they had not completed staff appraisals for the 2022 and 2023 years. Management explained that while formal performance reviews have not been completed in accordance with policy, they monitor staff’s performance through informal methods.

The approved provider submitted a written response with clarifying information. The provider confirmed they will be a year behind in completing performance reviews and intend to complete the reviews for 2022 by the end of 2023. The provider submitted a Plan for Continuous Improvement demonstrating the actions planned to address the areas of improvement. Actions include developing a plan to complete formal performance reviews in 2024, and to develop a process for informal performance reviews. The provider asserts that formal performance reviews are not the sole process they use to manage the performance of staff, and that informal processes are in place where management assess and monitor staff while working alongside them on the floor. The response did not include additional information or supporting evidence to demonstrate how the service will implement and manage the plan for workforce performance reviews once developed, or to verify the informal monitoring or review of workforce performance is actioned in practice.

I have reviewed the evidence in the assessment team report and the providers response. While I acknowledge the remedial actions planned by the provider in response to the assessment team report, it will take some time to fully implement and evaluate the effectiveness and sustainability of these actions. The providers response did not demonstrate that an effective system is in place, or the provider has sufficient capacity to effectively implement, manage and sustain improvements to ensure the performance of the workforce is regularly assessed, monitored and reviewed. I find requirement 7(3)(e) is non-compliant.

Requirement 7(3)(d)

The Assessment Team found that while all staff said they had received manual handling and infection control training, they did not recall completing any other mandatory training or education. When interviewed by the Assessment Team, several staff failed to demonstrate knowledge of the Quality Standards or Serious Incident Response Scheme (SIRS). Education records demonstrated limited training delivered for the past two years. Service policy documentation demonstrated that staff should receive regular training and education monthly. While consumers and representatives were confident in staff ability to deliver care and services, a representative felt staff required more training in dementia and behaviour management. Management said that due to time restraints, they had not been able to arrange any additional training.

The approved provider submitted a written response with clarifying information and a Plan for Continuous Improvement (PCI). The provider agrees that due to the complex nature of the consumer cohort, staff could benefit from dementia and behaviour management training, and stated that this has also been raised by staff. The provider stated they plan to include dementia training as part of upcoming staff meetings. The provider agrees that education during COVID-19 was sparse, and that two lots of manual handling and fire training have been completed, with further training in infection control, elder abuse, SIRS, restrictive practices and open disclosure scheduled for later in the year.

In response to staff being unaware of SIRS or the Quality Standards during the assessment contact, the provider asserts the staff interviewed were agency staff. The provider states they do not consider the training and education of agency staff is their responsibility, however, have included a planned action in their PCI to develop an orientation checklist for agency staff which includes basic training in SIRS, restrictive practices, Quality Standards, open disclosure and antimicrobial stewardship.

I have reviewed the evidence in the assessment team report and the providers response. While I acknowledge the remedial actions planned by the provider in response to the assessment team report, it will take some time to fully implement and evaluate the effectiveness and sustainability of these actions. The response submitted by the provider did not demonstrate that an effective system is in place, or the provider has sufficient capacity to effectively implement, manage and sustain improvements to ensure the workforce is trained and supported to deliver outcomes required by these Quality Standards. I find requirement 7(3)(d) is non-compliant.

Requirement 7(3)(a)

Most consumers and representatives said there is enough staff to deliver care and services. While most care and clinical staff were satisfied with staffing levels, not all care staff considered there was sufficient staff at the service. However, all staff said they can complete all tasks required during their shift. Management described the strategies in place to manage planned and unplanned leave including using permanent, and agency staff to fill shifts. In relation to agency staff, management described sourcing agency staff that are familiar with the consumers to ensure continuity of care. While the service demonstrated a new call bell system is in place, it is not currently producing reports. To manage reporting challenges, management said a manual process is in place to monitor call bell response times, to ensure call bell functionality and that call bells are activated. Consumers and representatives did not provide negative feedback in relation to call bell response times, reporting staff are responsive and attend in a timely manner. Staff were observed responding promptly to call bells. Roster documentation for the two weeks prior to the assessment contact demonstrated that all care and clinical shifts were filled, and a registered nurse was rostered each shift.

Based on the evidence, as summarised above, I find requirement 7(3)(a) is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| 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. | Non-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

I have assessed this Quality Standard as non-compliant as I am satisfied requirement 8(3)(c) is non-compliant:

The service was found non-compliant in Standard 8 in relation to requirements 8(3)(c) and 8(3)(e) following a site audit in November 2022 where it was unable to demonstrate:

* effective organisation wide regulatory compliance governance systems relating to environmental restraint
* a clinical governance framework that included policies relating to open disclosure, minimising the use of restraint and antimicrobial stewardship.

Requirement 8(3)(c)

While the Assessment Team found the service had implemented improvements to address the deficits in relation to regulatory compliance systems, the assessment team report identified governance systems in relation to information management, continuous improvement, feedback and complaints and workforce governance were not effective.

Deficiencies related to information management systems, with inconsistent and inaccurate documentation as identified in Standards 2 and 3; continuous improvement systems and feedback and complaints systems, with feedback, complaints and incidents not effectively recorded, reviewed, trended or analysed to inform continuous improvement; and workforce governance systems, with workforce training and performance not effectively managed.

The approved provider submitted a written response with clarifying information. The provider submitted a Plan for Continuous Improvement demonstrating the actions planned to address the areas for improvement. Actions include workforce training and performance reviews to be completed by end of year, development of informal performance processes, review of care plans and care consultation processes, inclusion of complaint data in the incident spreadsheet, and complaints and incident data reviewed and presented at upcoming staff and family meetings. The provider’s response includes broad commentary about the challenges of the COVID-19 pandemic and running a small standalone service. Being a small standalone service, the service does not have a Board, and the owner, who is also the provider, governing body, Director of Nursing and Clinical Care Coordinator manages and runs the service, with the support of an operations manager. While these external factors are not disputed, the provider remains accountable for the delivery safe, quality care and services and ensuring that it complies with the Quality Standards, and that includes ensuring effective governance systems are in place for information management, continuous improvement, workforce governance and feedback and complaints.

Based on the evidence in the assessment team report, including information in requirements 3(3)(a) and 8(3)(e) I am satisfied the service has demonstrated improvement actions to address the non-compliance in regulatory compliance systems through improving identification, assessment and informed consent processes to meet legislative requirements for consumers recognised as subject to environmental restraint. I am also satisfied the provider has demonstrated effective systems for financial governance.

I have reviewed the evidence in the assessment team report and the provider’s response. I have also considered information and the findings of non-compliance in Standards 2 and 7 in relation to assessment and planning documentation, workforce training and performance. While I acknowledge the remedial actions planned by the provider in response to the assessment team report, it will take some time to fully implement and evaluate the effectiveness and sustainability of these actions. The response submitted by the provider did not demonstrate that an effective system is in place, or the provider has sufficient capacity to ensure effective governance systems relating to information management, continuous improvement, workforce and feedback and complaints governance systems. I find requirement 8(3)(c) is non-compliant.

Requirement 8(3)(e)

At the September 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2022 site audit. The service demonstrated it had developed and implemented policies relating to clinical governance, open disclosure and antimicrobial stewardship. The service demonstrated it had updated its restrictive practices policy in accordance with legislative requirements.

The organisation demonstrated it has a clinical governance framework in place that provides an overarching monitoring system for clinical care. The framework, supported by a suite of updated policies and procedures, addresses key clinical governance areas such as antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure. Staff demonstrated understanding of the new policies and procedures and provided examples of the relevance to roles and responsibilities.

Based on the findings in the assessment team report, I am satisfied the provider has addressed the non-compliance and demonstrated a clinical governance framework is in place supported by antimicrobial stewardship, minimising the use of restraint and open disclosure policies and procedures. I find requirement 8(3)(e) is compliant.

Requirement 8(3)(a)

Consumers and representatives said they are supported to engage in the development of care and services through informal meetings with management, electronic group chats, and surveys. Due to the small size and structure of the service, management described the primary avenue to support and engage consumers and representatives is through verbal feedback mechanisms and electronic messaging (WhatsApp). Electronic messaging documentation reflected regular engagement with management. I have considered information relating to deficits in formal feedback and complaints processes and documentation processes under requirement 8(3)(c) in terms of feedback and complaints governance systems.

Based on the evidence, as summarised above, I find requirement 8(3)(a) is compliant.

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)