Performance

Report

**1800 951 822**

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| Name: | Elizabeth Jenkins Place Aged Care Plus Centre |
| Commission ID: | 0414 |
| Address: | 8 Homestead Avenue, Collaroy, New South Wales, 2097 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 3 April 2024 |
| Performance report date: | 6 May 2024 |
| Service included in this assessment: | Provider: 943 The Salvation Army (NSW) Property Trust  Service: 430 Elizabeth Jenkins Place Aged Care Plus Centre |

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 Elizabeth Jenkins Place Aged Care Plus Centre (**the service**) has been prepared by Therese Solomon, 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.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **Not Applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 3

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

Findings

Consumer and/or representative feedback, as well as observations and a review of care and service documentation was reflective of the service’s ability to demonstrate their compliance with the management of high-impact and high-prevalence risks. Management identified their consideration for high-impact and high-prevalence risks were associated with falls prevention and management, choking risks and weight loss management, and behaviour management.

Whilst behaviour management was observed to be occurring throughout the visit, the Assessment Team identified an area for improvement related to consumer documentation. Staff and management demonstrated a strong understanding of each consumer and their needs, and feedback from consumers and their representatives was overwhelmingly positive regarding the management of consumers with behaviours of concern.

A review of care and service documentation for consumers who have had falls reflected they were managed as per the organisation’s falls policy and procedure. Management advised the Assessment Team that falls were consistently monitored both at a service and an organisational level. There are weekly high-risk meetings which occur on a service level and monthly clinical risk meetings which occur at an organisational level. The falls prevention and management are noted to be standard agenda item for discussion.

A review of care and service documentation for consumers who have been identified as choking risks showed they were managed as per the organisation’s policy and procedure. Management advised the Assessment Team that choking risks and weight loss were consistently monitored both at a service and an organisational level. There are weekly high-risk meetings on a service level and monthly clinical risk meetings which occur at an organisational level.

Service management reported when a medication incident occurs, the effected consumer is closely observed, immediately reviewed by their medical officer and, where appropriate, transferred to hospital for observation. An incident form is completed, and open disclosure occurs with consumers and their representatives, who are informed of the incident and updated of the consumer’s health status. Administering clinical staff are provided with further education, guidance, and supervision once an incident occurs and must complete mandatory training in medication management before attending to further medication rounds.

Consumer medications are reviewed every three months by their medical officer in liaison with consumer representatives where required. It was observed by the Assessment Team that these reviews are timely and include the review of psychotropic medications. Medication charts and the psychotropic register for the service reflects that medications were observed to be minimised where possible. There have been no medication incidents in the last six months where a consumer has needed hospitalisation or medical attention.

Care and services documentation reflects consumers who experience responsive or changing behaviours are assessed and monitored. Behaviour management strategies were personalised for each consumer, and it was reflective of each consumer’s needs. Representative feedback was positive regarding staff management of behaviours of concern and the ongoing emotional support provided to consumers, and their representatives, who are living through and experiencing a diagnosis which includes behavioural challenges. The Assessment Team identified areas for improvement related to behaviour support planning and behaviour charting documentation, however observations of staff interactions with consumers demonstrated staff were aware of individualised strategies for each consumer and were able to implement the strategies effectively.

Based on the information provided by the Assessment Team, Requirement 3(3)(b) is found 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 |

Findings

Consumers and/or representatives consistently stated there are adequate numbers of staff available to meet consumer needs and staff attend to personal care in a timely manner.

Two consumer representatives reported on occasions personal care was delayed due to insufficient staffing levels in the memory support unit, specifically during lunch periods, which resulted in negative outcomes for one consumer. However, the management team stated they are aware of staffing level concerns in the memory support unit and have implemented an additional fulltime registered nurse to guide and support care staff. The management team stated staffing levels and consumer needs are under review and monitored in the memory support unit to develop strategies to ensure the safety and quality of care and services for consumers.

Staff described how staffing levels are sufficient during most shifts and how, on occasion, staff are difficult to replace during unexpected sick leave. The service has seven houses with a maximum of eighteen consumers per house with three care staff members for each. The service has four registered nurses for day and afternoon shifts and one registered nurse for night shift. Additionally, the service has four lifestyle staff members and up to two Certificate III trainees available to support consumers for each house during day and afternoon shifts.

The management team stated a staff alert is sent via text to all staff members to cover vacant shifts and unexpected sick leave or agency staffed is used as a last resort. Rosters are created six weeks in advance and vacant shifts filled before the final release of rosters. The management team are working on assigning staff members to specific houses to ensure a continuity of service and familiarity with consumers’ needs and preferences.

Documentation showed most shifts were filled in the two weeks prior to the Assessment Contact, with a minor number of shifts not covered due to unexcepted sick leave which were unable to be filled. The management team stated they have a strategy to increase permanent employees through recruitment advertising, student placements and incentives such as gift vouchers and improved work/life balance. Staff members confirmed there has been an increase in care staff and registered nurses in the past three months.

Based on the information provided by the Assessment Team, Requirement 7(3)(a) is found 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)