Performance

Report

**1800 951 822**

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| Name: | Elizabeth Lodge Hostel |
| Commission ID: | 0179 |
| Address: | 79 Mt Pleasant Avenue, Wahroonga, New South Wales, 2076 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 26 February 2024 to 27 February 2024 |
| Performance report date: | 3 April 2024 |
| Service included in this assessment: | Provider: 2841 Seventh-day Adventist Aged Care (Greater Sydney) Ltd  Service: 195 Elizabeth Lodge Hostel |

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 Lodge Hostel (**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 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **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

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 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated effective review of care and services which are reflective of the needs, goals, and preferences of each consumer. Consumers and/or representatives stated they are informed of changes to care and were provided updated care plans. Clinical and care staff were able to tell the Assessment Team how they personalise care for each consumer and identify the needs and risks of each consumer they care for and were able to provide personalised examples. Clinical files reviewed by the Assessment Team indicate that consumers are being consistently assessed by clinical staff, changes in consumer health are being identified and care is being reviewed and altered when appropriate.

Consumers and/or representatives confirmed there is regularity in the review of the clinical and care documents. Representatives stated staff contact them when the consumer’s condition has changed, when the consumer is reviewed by their local medical officer, and to discuss a transfer to the hospital if required. If necessary, changes to care and services are implemented.

Clinical staff and management reported they follow a schedule for review of care plans, scheduled for every three months. A monthly resident of the day assessment is also conducted to check on consumer status and function. The service was able to demonstrate that each consumer and their care and services are being reviewed regularly and as required, and each review is thorough and relevant to consumer needs. Each review takes into consideration the preferences and goals of each consumer.

# 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 |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives provided positive feedback regarding clinical and personal care provided to consumers within the service. Clinical and care staff demonstrated sound knowledge in personalised consumer needs and preferences. Documentation reviewed by the Assessment Team is consistently reflective of care and services provided by staff. The service was able to demonstrate that corrective actions from previous Assessment Contacts have been effective and consumers are now receiving appropriate care which is best practice, optimises their health and wellbeing and is personalised in nature.

In relation to skin integrity, risk assessments are completed within a timely manner to identify consumers who are at risk of pressure injuries, bruises, and other skin conditions. Head to toe skin assessments are conducted following a consumer’s return from hospital, as per the service’s return from hospital checklist, with any changes including bruises, pressure injuries or skin tears being identified and documented. Interventions such as the use of pressure relieving devices, skin moisturisation and pressure area care are recorded within a consumer’s care plan and within nursing progress notes.

In relation to wound care, the service has policies and procedures in place to guide staff in best clinical practice for wound management. Staff were knowledgeable in wound management procedures and the escalation of wounds when issues arise. They were aware of the referral process for an external wound consultant utilised by the service, and this was evident within consumer documentation. Wound charting was consistent, and photographs were regular and reflected the use of a measuring device. Documented treatment plans were followed and if a consumer has multiple wounds, each wound was documented on its own chart and had an individualised treatment plan.

The service has policies and procedures to guide staff in the care of consumers and professional practice in the management of diabetes, weight loss and nutrition and hydration. These policies outline the responsibilities of care and clinical staff in the management of these consumers, including the monitoring, reporting, and escalating of a change in a consumer’s condition.

Regarding the management of consumers with diabetes mellitus, a review of consumer files was noted to include an individualised diabetes management plan, which outlines the responsibilities of staff in relation to the management of consumers with diabetes mellitus, including processes involved in managing out-of-range blood glucose levels. Care staff were aware of their responsibility to report any changes in a consumer’s condition to the clinical staff on duty and all staff were able to identify where hypoglycaemic kits were located throughout the facility. Clinical staff demonstrated a clear understanding of consumers’ diabetes management plans and consumer documentation showed clinical and care staff were taking appropriate steps, as per instructions, to ensure consumer safety regarding diabetic management.

Documentation reviewed confirmed for consumers with a high falls risk or a history of falls, a falls risk score and a falls risk assessment was documented within their clinical file. The service has a falls management plan and with each fall that occurs, it was observed that staff have appropriately assessed, managed, and escalated the incident according to the services’ policy and procedures. Assessments after a consumer experiences a fall are appropriate and timely. Consumers who fell were escalated appropriately and referred to their local medical officer and physiotherapist for review and reassessment. Further prevention strategies were documented, and representatives were updated when an incident occurred and when a change in care and services was deemed necessary to aid in the prevention of falls.

Clinical and care staff demonstrated an understanding of identifying unplanned weight loss and the process of escalation if required. Care staff described how each consumer’s weight is documented monthly as part of the service’s resident of the day initiative and were able to identify consumers who were on weekly weight checking due to previously identified weight loss and monitoring. Care staff stated they report any concerns to the clinical staff regarding a consumer’s change in appetite. Clinical staff explained the process for investigation and escalation if a change of a consumer’s condition is reported or observed, including review by the consumers’ medical officer and a referral to an allied health professional such as a dietician or speech pathologist if required. A review of consumer files demonstrated the service is effectively monitoring the weight of consumers and identifying changes, escalating concerns, and implementing strategies to assist in the management of consumers’ nutrition and hydration requirements.

Consumer documentation reflects that consumers who have responsive or challenging behaviours are assessed and monitored. Behaviour management strategies and interventions are implemented and used to minimise and reduce the behaviour of concern. Strategies are personalised for each consumer and have been documented within behaviour support plans. Behaviour charting is consistent and reflective of the evaluation of each strategy used. Staff were able to demonstrate individualised strategies for each consumer and strategies were observed to be utilised throughout this Assessment Contact.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service was able to demonstrate feedback and complaints are recorded, reviewed, considered, and used by the service to improve the quality of care and services. Consumers and/or representatives were able to describe changes made at the service as a result of feedback or complaints provided by consumers, including implementing weekly cleaning of balconies to increase the use of the balconies by consumers and visitors.

Review of the service’s plan for continuous improvement and complaints register, demonstrated continuous improvement actions have been instigated following the making of complaints, feedback, and suggestions by consumers, representatives, and staff. Staff demonstrated a clear understanding of the processes for capturing feedback or complaints provided by consumers and representatives, including feedback provided verbally. Staff advised most consumers or representatives choose to submit the service's compliments and complaints form, to provide feedback and said some consumers or representatives may approach staff or management directly. Staff stated they will complete a feedback form to capture verbal feedback from consumers and/or representatives.

Management explained how feedback and complaints are collected, analysed, and trended, using an electronic software program, and described how feedback data is reviewed, and monitored from the service level through to the governance level. Management advised the service’s feedback forms are collected weekly from each level of the service and the information is entered manually into the organisation’s electronic reporting software. The software generates reports and conducts trend analysis on the data, and this information is reviewed by the management team and discussed at monthly management meetings. Trends are identified and strategies are discussed to improve the consumers’ experience, and the care and services being provided. Management advised these reports are submitted to the Board and discussed at an organisational level.

# 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. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives expressed confidence in the ability of staff to deliver care and services, and said they believe staff are well trained and equipped to perform their roles. They did not identify any areas where they thought the staff could benefit from extra training.

Review of training reports identified 95% of all staff, including those on leave, had completed mandatory training including, but not limited to, code of conduct, elder abuse, restrictive practice, the Serious Incident Response Scheme, and the Aged Care Quality Standards. Management explained the service uses feedback from consumers, clinical indicators, incidents, and staff performance reviews to identify staff training needs.

The service’s training calendar mapped out education sessions planned for the upcoming year of 2024 including, but not limited to, antimicrobial stewardship, open disclosure, infection prevention and control and the management of incidents, falls and wounds. The calendar also included planned education sessions to be conducted by external providers including representatives from allied health service providers and healthcare product suppliers.

Staff across all areas of the service indicated they have participated in face-to-face training provided at the service and completed ongoing training modules using an electronic learning platform. They confirmed completion of mandatory training requirements including skills-based competency assessments for hand hygiene, donning and doffing personal protective equipment, and manual handling.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Staff confirmed they participate in performance reviews and were given an opportunity to raise any training needs. Management described a new system implemented at the service to monitor staff appraisals. This includes a monthly calendar alert which notifies management of staff requiring a performance review and communication to staff informing them of their upcoming performance appraisal. Staff appraisals requiring action are discussed in the daily leadership meetings.

The director of nursing stated staff performance is also reviewed using consumer and staff feedback, investigation of incidents, review of clinical data, staff meetings, and observations by management. Evidence of performance management was noted in the service’s complaints register, following feedback provided regarding the performance of a staff member.

The service was able to demonstrate effective systems are in place to identify deficiencies in staff skills and/or knowledge and to recognise, and respond to, additional training requirements.

# 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. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation was able to demonstrate effective governance systems are in place in relation to continuous improvement, workforce governance and legislative compliance.

Management advised continuous improvement initiatives are drawn from a variety of sources, including consumer, representative and staff feedback and complaints mechanisms, regular analysis of clinical and incident data, internal audits, and identification of deficiencies in staff knowledge. Management described improvement initiatives, outlined in a plan for continuous improvement, at both the service and organisational level.

The Assessment Team reviewed the plan for continuous improvement for both the service and the organisation which identified the planned and completed improvement actions in relation to various areas of care and service delivery. The plan for continuous improvement contained actions implemented to address feedback received in relation to the quality of food provided at the service, including external education sessions for staff, and liaising with external services in relation to the development of the menu at the service.

Management stated ongoing recruitment occurs and described how some members of the service’s workforce, previously employed as care staff, recently gained higher education qualifications. These staff members have been recruited and trained in clinical positions at the service, assisting in the development of a stable workforce. Management advised they do not have a high need for the use of agency staff and if agency staff are required, they request members of the workforce who have attended the service previously. This promotes continuity of care and services provided to the consumers.

Responsibilities for all roles are clearly set out in position descriptions and management regularly monitors and reviews the performance of staff. A review of service documentation demonstrated all staff reviews to be up to date and performance management being conducted when required.

The service advised changes to legislative requirements are monitored and brought to the organisation’s attention through communication received from governing bodies, which is then communicated through to the service level. The organisation stated policies and procedures are updated to reflect these changes and education is provided where required, such as for the code of conduct, Serious Incident Response Scheme, and restrictive practices.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation was able to demonstrate it has policies and systems in place to effectively identify and manage risks in relation to high-impact and high-prevalence risks to consumers, abuse and neglect of consumers and incident management.

Clinical data relating to high impact or high prevalence risks for consumers is collected and analysed in the areas of falls, pressure injuries, medication errors, wounds, and weight loss. The service provided a high impact high prevalence risk register, which is discussed at monthly management meetings and clinical meetings. This register is updated accordingly to assist in tracking and monitoring consumers with identified high risks, ensuring they receive the care and services they require.

The service’s incident register report reflects data analysis is taking place and an investigation is conducted when incidents occur. Contributing factors and areas for improvement are identified and actions are taken as necessary. This information is discussed monthly by the director of care at the service level and presented to the Board through the aged care management and clinical governance committee.

A review of incidents and the Serious Incident Response Scheme register demonstrated the service has a strong understanding of their mandatory reporting requirements regarding incidents related to abuse and neglect of consumers. The Serious Incident Response Scheme register showed incidents are escalated and reported within the legislative timeframes and appropriate actions taken in response to the incidents.

Staff confirmed they have received education on incident management and their responsibility under the Serious Incident Response Scheme. They could describe the steps they would take in response to an incident, including caring for the consumer’s immediate needs, recording, and reporting the incident and follow up action as needed. Staff demonstrated an understanding of consumers with high impact high prevalence risks and how they implement the service’s policies in alignment with best practices.

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)