Performance

Report

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| Name: | Fairlea Aged Care @ Rosehill |
| Commission ID: | 2177 |
| Address: | 145 Good St, ROSEHILL, New South Wales, 2142 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 26 September 2023 to 27 September 2023 |
| Performance report date: | 7 December 2023 |
| Service included in this assessment: | Provider: 2310 Trinity Aged Care Pty Ltd  Service: 684 Fairlea Aged Care @ Rosehill |

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 Fairlea Aged Care @ Rosehill (**the service**) has been prepared by T 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.
* the provider’s response to the assessment team’s report received 6 December 2023.

# 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 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)(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. | Compliant |
| 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

Registered nurses and the management team stated the value of identifying consumers’ care and service needs and preferences using validated tools to assess health risks. The Assessment Team observed staff adhering to established policies and procedures for assessment and care planning and consumer care plans contained evidence of thorough risk assessments and customised strategies to alleviate identified risks.

Consumers and/or representatives expressed their active engagement in the assessment and care planning process, underscoring its significance in ensuring safe and effective care delivery. However, the Assessment Team identified that the service had not yet completed the transfer of all consumers information and care needs into the new electronic care management system.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(a) is found Compliant.

The Assessment Team identified that care and services are not consistently reviewed for effectiveness or when incidents impact on the needs of consumers.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found 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 |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Consumers and/or representatives expressed satisfaction with the care they received, highlighting its safety and appropriateness. However, the Assessment Team identified some inconsistencies related to pain management for consumers. The Assessment Team reviewed policies related to psychotropic medication usage, restrictive practices, and pain management.

Registered nurses confirmed restrictive practices were reviewed every three months by a medical officer and outcomes of reviews discussed in daily handover meetings to keep staff informed. Staff members discussed their approach to using restrictive practices, emphasising the prioritisation of alternative strategies as the initial intervention and the continuous monitoring of consumers who received psychotropic medication.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found Compliant.

The service demonstrated it has processes in place to manage high impact high prevalence risks. Falls are a high impact risk for consumers, and staff are aware of and monitor high falls risk consumers. Several interventions were noted in the daily tasks regarding falls including regular checks, appropriate footwear, regular toileting, ensuring glasses or hearing aids are in use, walking aids are within reach and scheduled walks with those requiring assistance.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Compliant.

Requirement 3(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 demonstrated staff were able to recognise and refer concerns regarding consumer status, change in condition or deterioration. Processes are in place to guide staff in referral processes to the medical officer, transfer to hospital, and post incident monitoring and review.

The Assessment Team reviewed the service's policy and procedure related to the management of consumers health deterioration which provides clear guidance and protocols to ensure the timely identification and appropriate response to any signs of health deterioration in consumers.

Registered nurses and the management team explained the service's referral process, emphasising their responsibilities in managing referrals from the medical officer and coordinating with external care providers when necessary. In response to feedback received from the Assessment Team regarding referrals, the management team committed to addressing the referral concerns by incorporating it into the agenda for the upcoming fortnightly clinical team meeting. They also expressed their intention to discuss this further with the representatives to obtain their consent for the referrals.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(f) is found Compliant.

Requirement 3(3)(g) 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 there is a visitor screening process in place, and visitors were observed to complete rapid antigen tests, donning of required personal protective equipment and a surgical face mask before entering the service. Hand washing and alcohol-based hand wash is readily available throughout the service and staff and consumers were observed to be practising hand hygiene.

The Assessment Team observed staff consistently adhered to stringent infection control and prevention measures. This included hand hygiene practices, the correct usage of personal protective equipment such as masks and gloves and maintaining a clean and hygienic environment when delivering care to consumers. Staff members confirmed their comprehensive understanding of infection control protocols and displayed a proactive approach by ensuring all visitors completed a health status declaration before entering the premise. The service prominently displayed signage throughout the facility, serving as a reminder to both consumers and visitors about the importance of frequent handwashing and infection control measures.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement 6(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.

Consumers and/or representatives confirmed the service efficiently addresses their complaints and reported they do not have significant complaints or concerns regarding the quality of care and services provided. Documentation shows staff have received training and education on open disclosure and procedures for addressing issues when things go wrong. Information relating to the organization's open disclosure policies and procedures are readily accessible and integrated into the service handbook, website, and complaint form.

Staff demonstrated a sound understanding of the key principles of open disclosure in alignment with the organization's policies and procedures. Staff showed how they incorporate open disclosure into their daily interactions with consumers through practical examples when things go wrong, such as providing apologies and clear explanations of events, attending to immediate needs, and implementing preventive measures.

Documentation shows the open disclosure process is being used in interactions with consumers and/or representatives.

# 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)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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. | 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)(a) 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 has monthly resident and representative meetings, and documentation shows participation of consumers and representatives in providing feedback relating to care and services and suggestions for improvements. The board is provided with resident and representative meetings minutes and collaborates with the management team to implement improvements.

Consumers and/or representatives provided positive feedback regarding the responsiveness of the service to concerns they raise and noted improvements such as an increase in staffing levels and enhancements in the quality of meals.

The board regularly gathers feedback on consumer satisfaction through surveys, complaint forms and input from the management team. Staff members stated they provide feedback from consumers and representatives to the management team and have undergone training in person centred care in relation to consumer complaints and feedback.

Requirement 8(3)(b) 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 stated they feel the service listens to their needs and addresses their concerns relating to care and services. Consumers and/or representatives provided feedback requesting more culturally appropriate food options, and in response, the service has incorporated a greater variety of culturally appropriate inspired meals into the menu.

Staff confirmed the service consistently communicates organizational values and the management team demonstrate positive behaviours in alignment with these values. Staff receive communications from the board through email, memos, education, and training. Staff stated they feel supported by the management team and feel safe in providing feedback and having their concerns addressed.

The board is informed and oversees the service's culture by reviewing a range of reports, including clinical indicators, resident and representative meetings, surveys, and feedback from staff members. The board and the management team meet regularly to monitor and review key cultural indicators and trends and provide direction to promote a safe and inclusive culture.

Effective organisation wide governance systems relating to continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were demonstrated.

The board conducted a comprehensive review of data and information relating to legislative requirements for workforce governance, along with feedback from staff and the management team regarding the necessary staffing levels to ensure safe and quality care and services. In response, the board increased staffing numbers to guarantee consumers receive quality care and services while mitigating risks. The board has strategies to attract and retain sufficient staffing levels, with a focus on staff education, well-being, and work-life balance.

The board has subscriptions to industry peak bodies and receives information from the Commission and relevant government agencies to stay updated on legislative and regulatory compliance. Changes in legislation are communicated to staff through electronic system alerts through their individual digital login, and staff are required to acknowledge these alerts online.

Additionally, information related to legislative and regulatory compliance is shared with staff through daily handover meetings, training sessions, toolbox talks, text messages, and mobile applications. The management team monitors these channels to ensure staff have received and acknowledged messages.

The Assessment Team identified areas for improvement related to information management, specifically with the transfer of all paper-based information into the new electronic management system.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(c) is found Compliant.

The board and management team use a new electronic management system and regular meetings to identify and assess risks such as consumers on psychotropic medications. The implementation of the new electronic management system has an automate function to respond with suggested actions to guide staff members.

The board and management team assess risks and discuss how to find solutions to reduce and remove risks. The board uses external regulatory consultants for policy documentation to guarantee policies are based on the latest best practice. The board communicate risk policies and processes to staff through training and education, toolbox talks, regular staff meetings and electronic alerts. The clinical manager and registered nurses engage in a regular fortnightly meeting to discuss individual consumer risks and how to implement strategies to ensure safe and quality care.

Actions taken by the board to mitigate risks in relation to restrictive practices include the implementation of new electronic management system which reduces risks associated with the previous paper-based system which was not encouraging staff to enter, monitor and review or clinical care. The new electronic management system prompts staff to complete assessments and review and follow up on tasks such as clinical charts and observations.

The management team stated the increase in staff and training has reduced risks through the ability for staff to provide increased monitoring of consumers and to review consumer information to address issues and update care plans. Staff have readily available access to strategies and can implement strategies and interventions with individual consumers as per their care plan information.

The Assessment Team identified areas for improvement related to the identification, management and assessment of risks associated with clinical care.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found 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)