Performance

Report

**1800 951 822**

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| Name of service: | Florence Price Gardens |
| Service address: | 11 Hackett Lane BALLINA NSW 2478 |
| Commission ID: | 2681 |
| Approved provider: | RSL LifeCare Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 7 February 2023 to 8 February 2023 |
| Performance report date: | 02 March 2023 |

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 Florence Price Gardens (**the service**) has been prepared by K. Reed, 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 - Site; the Assessment Contact - 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 27 February 2023
* information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| 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** |

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 |
| 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 |

Findings

Requirement 3(3)(b)

The Assessment contact record contained information that consumers with high impact risks had not been effectively managed. Documentation did not support consumers requiring pain management or oxygen therapy were receiving their prescribed care. Clinical governance and monitoring processes were ineffective in identifying deficits in documentation to demonstrate the delivery of prescribed care directives.

For one named consumer with a diagnosis including chronic pain, interventions to relieve their pain including heat packs and massage were not occurring, and the consumer stated they were in constant pain. Care staff confirmed heat packs and massages were not provided to the consumer, citing massage caused damage to the consumer’s skin integrity. Care directives for the consumer instruct staff to provide a therapeutic massage or heat pack to the consumer’s lower back, bilateral knees and right shoulder for 20 minutes weekly. These directives were commenced following a physiotherapy pain assessment completed 30 December 2022.

Following feedback at the Assessment contact, the physiotherapist stated massages had been ceased for the consumer due to the frailty of the skin on the consumer’s legs. There was no consideration to massaging the other areas of the consumer’s body which were noted to be sites of pain. There was also no documented evidence to support these changes were documented and pain assessment or evaluation had not occurred to ensure the consumer was pain free as possible. Care staff stated they had provided the consumers with heat packs; however, this did not align with feedback from the consumer. Management stated they would instruct staff to massage the consumer’s legs, despite the directive from the Physiotherapist.

The Approved provider submitted a written response to the Assessment contact report including a plan for continuous improvement. The response included information to support the named consumer was reviewed by clinical staff immediately after feedback was provided while the Assessment Team were onsite, and the consumer denied they had pain. Evidence was also provided the named consumer had a personality disorder which contributed to the consumer being an unreliable historian. However, staff continued to complete pain assessments for the consumer. Pain assessments completed for the named consumer over a seven-day period evidenced one episode of pain which was managed effectively with medication.

The Approved provider acknowledged the directives in the pain assessment were unclear and education has been provided to staff to reaffirm the directives. Training records evidenced 25 staff members attended pain assessment training. The named consumer was reassessed by the Physiotherapist 08 February 2023 and determined massage to the consumer’s lower limbs was contraindicated and heat packs are to be applied to the consumer’s lower back and/or right shoulder, this information was contained in the pain assessment/management plan completed by the Physiotherapist.

I am satisfied with the actions taken by the Approved provider immediately and subsequently to address the named consumer’s pain management. This information has been considered in my decision that Requirement 3(3)(b) is Compliant.

For three named consumers requiring oxygen therapy via an oxygen concentrator, and care documentation listed several actions in relation to checking, cleaning and monitoring the oxygen equipment. Care staff confirmed they were unaware of these directives and had not attended to them. The flow rate for the oxygen concentrator was to be checked on each shift, the nasal prongs were to be checked to ensure they were fitted correctly, the concentrator filter was to be washed weekly, the tubing to be changed monthly and daily integrity checks of the tubing was to occur. The named consumers could not recall staff checking, changing or cleaning their oxygen equipment. While observations indicated the equipment appeared clean there was no documented evidence to support the directives to support the safe administration of oxygen had been completed. Following feedback, management stated an individualised checklist would be implemented to monitor, manage and maintain the consumer’s oxygen therapy.

Following feedback provided at the Assessment contact, management committed to undertaking several actions including the implementation of a cleaning and monitoring schedule a checklist to include changing of masks, three monthly review of oxygen management plans, a review of policies to reflect changes and to guide staff. The oxygen concentrators were cleaned for the three named consumers.

In accordance with the Approved provider’s response to the Assessment contact report, the Approved provider acknowledged there was no documented evidence in the three consumers’ clinical files to evidence the daily monitoring and weekly changing of oxygen therapy equipment.

The following actions have been taken following the Assessment contact:

* Education was provided to registered and care staff relating to oxygen therapy application, considerations, cleaning, changing and documentation requirements. This education was provided by the Regional clinical educator on 20 and 21 February 2023. Education records support 24 staff attended education relating to oxygen therapy.
* The three oxygen concentrators in use at the service were serviced by an external contractor on 10 February 2023. This process was evidenced by the Approved provider in its response by an invoice from the external contractor supporting the servicing of the concentrators.
* Oxygen therapy was discussed at the registered staff meeting on 24 February 2023 and the weekly care planning meeting 15 February 2023. Minutes from the Care Planning and Management meeting minutes evidenced oxygen therapy was discussed under the topic Specialised care.
* An email was sent to registered staff 17 February 2023 outlining their roles and responsibilities in relation to oxygen therapy management. These responsibilities were also contained in care planning directives for the three named consumers requiring oxygen therapy.
* Medication charts submitted by the Approved provider evidenced medication orders from Medical officers were evident for the consumers and their prescribed oxygen rates. Oxygen prescription letters were also submitted as part of the Approved provider’s response.

While I note there has been any recorded negative impact for the consumers in relation to the care of equipment to supply their prescribed oxygen therapy and the deficiency in the daily monitoring and weekly changing of oxygen therapy equipment documentation has been sufficiently addressed by actions taken by the Approved provider. Further actions are required in relation to the management of oxygen therapy, for example:

* While the Care planning and management meeting minutes contain information to evidence three consumers require oxygen therapy, handover notes submitted by the Approved provider, note on Page 21 another named consumer requires oxygen therapy as required. This consumer has not been identified by the service as requiring oxygen therapy and is not reflected in the Care planning and management meeting minutes.
* I also note the care planning for the first named consumer who required oxygen indicated staff are to apply the oxygen at 2ltrs per minute, however no information was recorded to indicate the oxygen was to be applied as necessary (as per the prescribed orders) and not continuously. This information was also omitted from the handover sheet.
* For another named consumer who requires oxygen, the medication chart stated the consumer is to receive a minimum of 16 hours per day of oxygen, these directives are not reflected in their care planning guidelines or the handover sheet. Care planning guidelines direct staff to apply the oxygen at 2ltrs per minute, however the medication chart directs staff to apply between 2 and 3ltrs of oxygen per minute. These directives are lacking from care planning and handover notes.

In coming to my decision of Compliance relating to Requirement 3 (3) (b), I have weighed the actions taken by the Approved provider and the risks associated with the above deficits identified and have come to the conclusion a lack of documentation does not equate to ineffective management of high impact risks and I have confidence the Approved provider will address the deficits as listed above.

Therefore, my decision is Requirement 3(3)(b) is Compliant.

**Requirement 3(3)(d)**

Care planning documentation reflected the identification of, and response to, deterioration or changes in consumers’ condition. Registered staff explained the assessment process following changes to a consumer’s condition. Staff confirmed they reported changes to clinical staff. If a consumer deteriorated after business hours, staff could telephone a Medical officer or transfer the consumer to hospital. Clinical records indicated consumers were regularly monitored by registered staff and if deterioration or change of a consumer’s mental, cognitive or physical function, capacity or condition occurred, this was recognised and responded to in a timely manner and representatives were notified. Registered staff were available at the service 24 hours a day, seven days per week. Staff described a range of indicators relating to deterioration, including changes in mobility, appetite and changes in behaviour. Other specialist services available to consumers included a Physiotherapist, Podiatrist, Dietitian and Speech pathologist.

Based on this information, it is my decision Requirement 3(3)(d) is Compliant.

# 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

Complaints or feedback provided by consumers through various methods were actioned in accordance with the service’s feedback and complaints policy. Staff described the process for assisting consumers to provide feedback. Consumers provided positive feedback in relation to actions taken in response to complaints and feedback. Complaints were noted to be recorded in the Consumer meeting minutes and the Complaints and feedback register.

The Serious incident register evidenced all incidents had been recorded and investigated including police involvement where necessary. When able care staff took appropriate action to resolve consumers complaints immediately. Staff had a shared understanding of open disclosure. Complaints that had been raised in the service’s feedback and complaints register had been actioned, resolution had been recorded and open disclosure had been provided by staff and management.

Based on this information, it is my decision this Requirement 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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Requirement 7(3)(a)

The number and mix of members of the planned workforce were deployed to deliver safe and quality care and services. Consumers and representatives provided positive feedback relating to the timeliness of assistance to consumers and the quality of care delivered. Staff confirmed they had sufficient time to complete their duties. If agency staff are utilised for unplanned leave, they followed a checklist to determine their competency. Daily monitoring of call bell response times was undertaken, and lengthy call bell response times were investigated.

Requirement 7(3)(c)

Staff had the qualifications and knowledge to effectively perform their roles. Consumers and representatives were positive in their feedback relating to staff competency. Management maintained a qualification, registration and competency register to monitor staff competency. Staff shared an understanding of the knowledge, skills and qualifications required for their individual roles.

Management confirmed they monitored staff competency through reviewing clinical indicators, care delivery and feedback from consumers and representatives. Staff were rostered to attend training and attendance was monitored. Staff confirmed they received up to date training on specific topics including wound care by wound specialists. The service maintained position descriptions for each role and monitored the currency of national criminal history checks and professional registrations.

Based on the information recorded above, it is my decision Requirements 7(3)(a) and 7(3)(c) are 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)