Performance

Report

**1800 951 822**

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| Name of service: | Gallipoli Home |
| Service address: | 11 Gelibolu Parade Auburn NSW 2144 |
| Commission ID: | 1071 |
| Approved provider: | Gallipoli Health Services Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 July 2023 to 14 July 2023 |
| Performance report date: | 17 August 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 Gallipoli Home (**the service**) has been prepared by G Jones, 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 4 August 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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 | **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 3(3)(a)**

* Ensure clinical and personal care provided is in line with best practice, tailored to consumers' needs and optimising their health and well-being, particularly in relation to restrictive practices and pressure injury management.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Care and services are culturally safe | Compliant |

Findings

Requirement 1(3)(d) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken improvement activities including staff training in consumer choice and how to support consumers in taking risks to live the best life they can. The service also introduced a new electronic documentation system which includes prompts and assessment forms for dignity of risk.

Consumers and/or their representatives said they are supported to live the best life they can and are supported to take risks. Consumer care planning documentation reviewed demonstrates consumer risks are assessed and interventions are put in place to minimise the risks to consumers.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | 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

This Quality Standard is assessed as compliant as five of five requirements have been assessed as compliant.

Requirement 2(3)(a) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including training/education for staff and the introduction of a risk register to capture each consumers’ assessed dignity of risk. In addition, all consumer care plans and assessments have been comprehensively completed, including a review of risk and behaviours, in consultation with the consumer,

The service was able to demonstrate that there are processes in place to ensure all relevant information is captured to ensure safe and effective care and services are delivered to all consumers. Care planning documentation shows a range of validated clinical risk assessment tools are completed on entry. Where risk is identified through assessment processes, management strategies are implemented to minimise associated risks. Management and staff explained the assessment process, how they identify risks and how consumers and representatives are involved in undertaking the assessments. All consumers have updated risk assessments, as required.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 2(3)(b) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including training/education for staff and the introduction of new processes to ensure consumer current care needs are captured and reviewed regularly.

The service was able to demonstrate how assessment and planning identifies and addresses the consumers’ current needs, goals and preferences, including advance care planning and end of life planning, if the consumer wishes. Management and staff explained the assessment and consultation process used at the service. Care plans reviewed by the Assessment Team show consumers have needs, goals, and preferences documented. Staff interviewed were able to provide examples of consumers’ preferences in line with their care plans.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 2(3)(c) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including training for staff, case conferencing with consumers, the introduction of a partnering in care programme and improved processes for communicating consumer needs and preferences between staff.

The service was able to demonstrate how assessment and planning is conducted based on ongoing partnerships with consumers and their representatives and includes other organisations.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 2(3)(d) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including case conferencing, care plan reviews and providing consumers with a copy of their care plan.

The service was able to demonstrate how outcomes of assessment and planning are effectively communicated to the consumer, documented in a care plan, and made available to the consumer.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 2(3)(e) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including improving handover processes, providing training and education on incident investigation/management and delivering person-centered care.

The service was able to demonstrate how care and services are reviewed regularly for effectiveness and when circumstances change, or incidents occur which impact on the needs, goals, and preferences of the consumer. The organisation’s assessment and planning policies outline the requirement for regular evaluation of consumer care plans with case conferences scheduled annually or when care and service needs change. Care planning and documentation for sampled consumers was reviewed and, in general, evidence supported compliance.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# 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. | Non-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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

This Quality Standard is assessed as non-compliant as one requirement has been assessed as non-compliant.

Based on the information provided by the Assessment Team and the Approved Provider Requirement 3(3)(a) is found non-compliant.

Requirement 3(3)(a) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including education and training for staff on person-centered care, understanding restraints, behaviour support plans, behaviour monitoring and use of non-pharmacological interventions. Additionally, all wounds have been reviewed by a wound consultant.

However, while the service has made considerable improvements in relation to providing safe and effective personal care and clinical care, gaps in staff knowledge and practices continue to impact the care delivered to consumers. The service was unable to demonstrate that each consumer receives safe and effective personal and clinical care that is best a practice and tailored to the consumer needs. While consumers and their representatives are generally satisfied with the care they are provided, review of documentation and staff practices did not support that care is in line with best practice, tailored to consumers' needs and optimising their health and well-being, particularly in relation to restrictive practices and pressure injury management.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings. The provider acknowledged further quality improvements are required and submitted a plan for continuous improvement. In their response, the provider supplied further information detailing actions taken to address deficits in care for the consumers identified in the Assessment Team’s report.

Requirement 3(3)(b) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including training and education for staff on wound management, falls prevention and infection prevention and control training. Additionally, risk register has been introduced. The service was able to demonstrate how they effectively manage high-impact and high-prevalence risks associated with the care of each consumer. Systems are in place for the management of high risk, high prevalence issues including falls, weight loss, diabetes and medication management, and behaviours of concern.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 3(3)(e) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including education and training for staff on information management with regular reviews of care plans and case conferencing occurring with consumers to ensure information documented is accurate. The service was able to demonstrate, through interviews and documentation reviews, that information about consumers’ conditions, needs and preferences are documented and communicated within the organisation and with others where responsibility of care is shared. Care documentation provides adequate information about the consumers’ condition, needs and preferences and is shared between organisations responsible for the consumer care. Sampled consumers and their representatives reported staff know them and their care needs well and information about their care needs is shared. The Assessment Team found some improvements could be made in the handover sheets used by staff for communicating key information and management stated they are working to address this.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement 4(3)(c) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including the appointment of more lifestyle and engagement staff, assessments and care plans have been updated and new lifestyle survey program has commenced.

Consumer care planning documentation reviewed includes a summary of the consumer’s preferences, detailed leisure and lifestyle assessments and care plans and activity charts. Consumers feedback informs the new monthly activity calendars. Consumers and/or their representatives expressed satisfaction with the activity program and said they are able to participate in the community, are supported to have personal relationships and participate in things of interest to them. The Assessment Team observed consumers engaged in meaningful activities throughout the assessment contact.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 4(3)(d) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including updating lifestyle and activity assessments and care plans.

Sampled consumers care planning documentation includes a summary of their preferences, detailed leisure and lifestyle assessments and care plans and activity charts. Staff interviewed had good knowledge of the consumers’ backgrounds and interests and have access to information about each consumer’s needs and preferences.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 4(3)(f) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including a review of meals, improvements have been made to the dining experience and a consumer food focus group set up. Staff education and training has been conducted on modified diets and improvements made to ensure timely updates of changes to consumers’ diets are entered into the new electronic documentation system.

Consumers and/or their representatives overall expressed satisfaction with the meals provided. The chef said they engage with consumers at mealtimes to gain feedback and identify specific likes and dislikes. Review of the four weekly seasonal menu identifies a variety of meals are offered to consumers. Observation of the mealtime service confirms consumers are offered fresh cooked appetising meals in a pleasant environment. Consumers in the memory support unit were observed being assisted to eat in a well-paced manner.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

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

Findings

Requirement 6(3)(c) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including staff education on complaints management and open disclosure. The feedback and complaints policy has been reviewed to guide staff practices and a complaints register established to manage complaints.

Consumers and their representatives interviewed stated they are encouraged and supported to give feedback and make complaints. Consumers confirmed management is responsive when complaints are made. Management explained how they respond to complaints as per their policy and provided evidence of open disclosure.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 6(3)(d) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the service has undertaken several actions including the collection and analysis of complaints data for trends to identify areas for improvement. This information is reviewed by the management team and by the Board. Food was a main issue raised in the complaints process and the service responded with a range of initiatives.

Management demonstrated that feedback and complaints are used to improve care and services providing multiple examples relating to improvements made in both the provision of clinical and personal care and in services and supports offered.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

# 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 |
| 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

This Quality Standard is assessed as compliant as five of five requirements have been assessed as compliant.

Requirement 8(3)(a) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the organisation has undertaken several actions including introducing consumer representation on the Board, establishing a bimonthly consumer advisory meeting for consumers and their representatives attended by the Board and management, and mechanisms to access consumer views on the food and the lifestyle program.

Consumers and representatives interviewed confirmed they believe the service is well run and said they were able to make comments, suggestions and complaints. In addition to the meetings mentioned above, management explained they encourage and support consumers and representatives to participate in the development, delivery and evaluation of care and services in other ways including the participation in surveys, providing feedback and complaints through the complaints mechanism, and input into auditing activities. Feedback from consumers and their representatives is used to identify areas for improvement and feed into the continuous improvement system.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 8(3)(b) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the organisation has undertaken several actions including the appointment of a medical officer to the Board to bring a knowledge and understanding of clinical matters as well as make a contribution to the clinical governance and medication advisory committees. All Board members have undertaken governance training. The organisation has also established a quality advisory committee to provide greater oversight of the care and services delivered.

Management demonstrated how the Board ensures the Quality Standards are met and how the Board promotes a culture of safe, inclusive and quality care. The Board assures itself the service is meeting the Quality Standards through review of key performance indicators, clinical data, auditing results, incident and complaints data. The organisation recently conducted a strategic planning workshop for staff, management and non-executive staff to review the first 5 years of the service, strategic matters, and long-term options.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 8(3)(c) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the organisation has undertaken a number of actions.

With regard to information management the organisation has implemented several actions including the introducing a new electronic clinical documentation system to better meet the needs of the service. The transition from the old system is now mostly complete. The new system enables management to better retrieve data for monitoring and auditing, and has improved oversight of the care delivered.

The service now has information systems to provide all stakeholders with the information they need. Consumers receive information about the care and services provided when they first come to the service and on an ongoing basis. Staff interviewed stated they have the information they need to deliver the appropriate individual care and services to consumers.

With regard to continuous improvement the service has implemented several actions including established an auditing program which is integrated into the continuous improvement system along with complaints data. Management advised incident data will also soon be integrated into the same platform by the end of July 2023. Management are closely monitoring the delivery of care and services and, through this process, identifying areas for improvement. The Board review the plan for continuous improvement along with auditing and benchmarking data at each meeting.

The service has a continuous improvement system in place and identifies opportunities for improvement through input from a variety of different sources. The process is monitored at a local and organisational level and review of the plan for continuous improvement showed improvements are logged, implemented, and evaluated.

With regard to financial governance management stated they have the resources they need for the delivery of care.

With regard to workforce governance the organisation demonstrated it has a system for the planning and management of its workforce through the ongoing review of consumer care needs, clinical data, and feedback from consumers and staff.

With regard to regulatory compliance, the organisation has implemented several actions including subscribing to service which provides current aged care policies and regular updates thus ensuring their policies and procedures reflect the current legislative requirements. Regulatory changes are a standing item agenda at Board meetings.

Relevant communication and training are provided to staff in relation to changes and new requirements to enable the organisation to meet its regulatory responsibilities. The organisation demonstrated they are meeting their legislative responsibilities in relation to serious incident reporting.

With regard to feedback and complaints, the organisation has implemented several actions including reviewed their policies and procedures for managing complaints and ensuring complaints are being used to identify areas of improvement. Complaints data is provided to the Board and Board members has been provided training in open disclosure.

The service demonstrated feedback and complaints are used to inform continuous improvement.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 8(3)(d) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the organisation has undertaken several actions including realigning the responsibilities of senior staff to enable more oversight of risk management, the introduction of a risk management tool and risk register and providing further training for staff.

The organisation now has a risk management framework. Risk is identified through assessments, surveys, analysis of clinical data, feedback from staff, and complaints. Risks are rated, and action plans introduced to manage the risk. Risks are regularly reviewed and the effectiveness of risk mitigation strategies monitored through a variety of mechanisms. The organisation has a policy for consumer dignity and choice to support consumers’ dignity of risk. Consumers who choose to engage in activities that may have an element of risk have a dignity of risk assessment. This is done in collaboration with the consumer and strategies to minimise the risk are discussed.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

Requirement 8(3)(e) was found non-compliant following a Site Audit 30 November 2022 to 2 December 2022. Since that time the organisation has undertaken several actions including reviewing policies and procedures to ensure they are evidence-based, provided greater supervision and education to staff, and improved the monitoring of care and analysis of clinical data .

The organisation has a clinical governance framework which includes roles and responsibilities, policies and procedures, and monitoring and reporting processes. Policies and procedures guide staff in the delivery of clinical care including antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure and staff have been adequately trained in these areas.

The Approved Provider, in their response to the Assessment Team’s report, indicated their agreement with the findings.

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)