Performance

Report

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| Name of service: | Geegeelup Aged Care Facility |
| Service address: | 3 Scott Street BRIDGETOWN WA 6255 |
| Commission ID: | 7127 |
| Approved provider: | Geegeelup Aged Care Facility |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 March 2023 |
| Performance report date: | 27 April 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 Geegeelup Aged Care Facility (**the service**) has been prepared by M Glenn, 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.

# 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 consumers, representatives, staff and management;
* the provider’s response to the Assessment Team’s report received 14 April 2023; and
* a Performance Report dated 17 June 2022 for a Site Audit undertaken from 3 May 2022 to 5 May 2022.

# 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 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)(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 |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 3 May 2022 to 5 May 2022 where it was found the service did not demonstrate assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed and updated policy and procedures to cover wound management and skin integrity, bowel management and constipation.
* Updated the Handover sheet to improve monitoring of consumers’ bowel motions and care planning documentation to include prompts to review bowel motions for consumers at risk.
* Education provided to staff on wound, bowel and medication assessment and care planning.
* Devised audit tools to monitor the delivery of care and services.

At the Assessment Contact undertaken on the 30 March 2023, feedback received through interviews, and documentation sampled demonstrated risks to consumers’ safety, health and well-being are identified and assessed, with strategies to reduce risks outlined in care plans to guide delivery of care and services. Clinical staff described how risks to consumers’ health and well-being are assessed on entry through use of an admissions checklist, validated assessment tools and consultation with the consumer and/or their representative. Care files for five consumers identified known risks, including in relation to mobility, skin integrity and changed behaviours and included strategies to manage risks. All representatives sampled said they receive regular contact with management and staff and are encouraged to be involved in discussions related to care planning and to assist with the identification of risks.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers 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 |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 3 May 2022 to 5 May 2022 where it was found the service did not demonstrate each consumer received safe and effective care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to management of medications, continence and pain. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Employed a Registered nurse to provide clinical support in the afternoon shift.
* Updated policies and procedures, including wound, bowel, falls and medication management, to provide guidance for staff.
* Implemented a communication book to provide relevant information for clinical and care staff.
* Commenced clinical audits to monitor clinical care.
* Updated the incident form to include prompts for staff to ensure appropriate response, including referral and review of mobility assessments.

At the Assessment Contact undertaken on the 30 March 2023, care files sampled demonstrated consumers receive safe and effective personal and/or clinical care which is tailored to their needs, optimises their health and well-being and is best practice. Care files demonstrated provision of effective and appropriate care, including in relation to wounds, diabetes, enteral feeds, pain and continence, and evidenced input from General practitioners. Staff described personal and clinical care needs for sampled consumers in line with their assessed needs and preferences. All consumers and representatives sampled were satisfied with the clinical and personal care consumers receive, including in relation to management of wounds, pain and continence.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care compliant.

# Standard 7

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| Human resources | |  |
| 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 (3)(c) was found non-compliant following a Site Audit undertaken from 3 May 2022 to 5 May 2022 where it was found the service did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Recruited an additional Registered nurse to provide clinical support on the afternoon shift. The Registered nurse is currently working two shifts per week.
* Provided training to staff on medication management.
* Identified multiple staff, who had previously been assessed as medication competent, were overdue for annual re-evaluation. A plan to achieve competency within one month is being implemented.

At the Assessment Contact undertaken on the 30 March 2023, the workforce was found to be competent and able to perform their roles effectively. Training workshops have been delivered for carers and supervisors, including in relation to management of medications, bowels and falls. However, records identified that all nine supervisors were overdue in completing medication competencies. The provider’s response indicates staff who have not completed all components of this training by 30 April 2023 will be removed from their supervisor role until training is satisfactorily completed. The provider’s response also indicates all training data is entered onto a Staff training matrix to identify staff who are due refresher training, ensuring staff education remains current. The Training matrix is audited on a monthly basis. Two staff confirmed they had attended recent training on medication and bowel management, which included review of relevant policies, and consumers sampled were complimentary of staffs’ knowledge, skills and the delivery of care.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| 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

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 3 May 2022 to 5 May 2022 where it was found the organisation’s risk management systems were not effective in relation to managing and preventing incidents. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Updated and reviewed organisational policies, procedures and flow charts, including in relation to falls, bowels, and wound management.
* Provided staff education on identifying and responding to the abuse of consumers, managing and preventing incidents, medication management, and use of the incident management system.
* Implemented clinical audits.

At the Assessment Contact undertaken on the 30 March 2023, the organisation demonstrated an effective risk management framework that includes systems and practices to guide staff in recognising and responding to high impact or high prevalence risks, identifying and responding to abuse and neglect, supporting consumers to live the best life they can and managing and preventing incidents.

A range of processes are used to ensure staff identify, manage, escalate and mitigate risks to consumers. Staff were able to identify consumers with high impact or high prevalence risks associated with their care, and training records demonstrated staff have completed training in relation to identifying and responding to the abuse and neglect of consumers. While the Assessment Team’s report indicated the service had not reported any serious incidents since July 2022, the provider’s response indicates three Serious Incident Response Scheme (SIRS) reports were submitted in 2022 and all SIRS incidents are logged on a Mandatory reporting log and reviewed.

A Dignity of risk policy guides staff in supporting consumers to make informed choices about decisions that affect their lives. Where consumers choose to partake in an activity which includes an element of risk, Risk acknowledgement forms are completed and risks and mitigation strategies are documented. Staff described processes that enable consumers to take risks and how they support consumers to live their best life.

Staff described processes they follow when an incident occurs, what they do to make the consumer safe and how they escalate and report incidents. Incident data sampled demonstrated staff record appropriate investigations and actions in response to incidents. The Assessment Team noted while monthly incident data is collated, it is not analysed for any trends, however, review of December 2022 and January 2023 data identified no obvious trends. The provider’s response indicates a number of reports are generated on a monthly basis, with the capacity to report of specific data, as required. Trends from previous months are noted cumulatively on each report.

**Requirement (3)(e)**

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 3 May 2022 to 5 May 2022 where it was found the organisation’s clinical governance framework was not effective in relation to medication management, antimicrobial stewardship and minimising the use of restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Appointed an Infection prevention and control lead and implemented an infection control log.
* Provided education to staff relating to management and prevention of incidents, the incident management system, minimising use of restrictive practice and infection control.

At the Assessment Contact undertaken on the 30 March 2023, an effective clinical governance framework, inclusive of antimicrobial stewardship, minimising the use of restraint and open disclosure was demonstrated. A framework that includes a suite of policies and procedures, guides staff in the delivery of clinical care and services. Staff sampled were knowledgeable of the clinical needs associated with older people, antimicrobial stewardship, strategies used to minimise the use of restraint and open disclosure. An Infection incident recording log is in place, with data corroborated against the Antibiotic usage report received monthly by the prescribing pharmacy. The log to included dates of the identified infection, the associated consumer and a summary of each incident. Management and staff described strategies used to minimise the use of the restraint in accordance with sampled consumers Behaviour support plans.

For the reasons detailed above, I find requirements (3)(d) and (3)(e) in Standard 8 Organisational governance 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)