Performance

Report

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| Name: | Glendale Aged Care |
| Commission ID: | 3130 |
| Address: | 265 Heaths Road, WERRIBEE, Victoria, 3030 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 23 January 2024 |
| Performance report date: | 14 February 2024 |
| Service included in this assessment: | Provider: 1599 RSL Care RDNS Limited  Service: 1889 Glendale Aged Care |

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 Glendale Aged Care (**the service**) has been prepared by M.Waniczek, 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 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **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** |

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 |

Findings

The service demonstrated effective processes to manage high-impact or high-prevalence risks such as diabetes, weight, medication, and complex care management associated with the care of each consumer.

Consumers and representatives confirmed they receive their medication on time and raised no concerns regarding medication management. Management and staff described the high-impact and high-prevalence risks to consumers at the service and ways risk is minimised. Policies and procedures are available to staff in relation to the management of high-impact or high prevalence risks at the service.

The Assessment Team reviewed documentation for consumers requiring complex clinical care and found appropriate individualised care plans in place. In relation to diabetes management, there were clear medical practitioner directives for individual consumers, including indications for blood glucose level measurement, acceptable and reportable limits, and actions, as well as diabetic review dates. For catheter management, care plans contained information relating to daily care and assessment, including the date of the catheter replacement.

The Assessment Team noted that the service weighs consumers, at minimum, monthly and more frequently where risk is identified. Consumers who lose more than two kilograms in one month or exhibit steady weight loss over several months are monitored weekly and referred to their medical practitioner or a dietitian. Those consumers requiring therapeutic monitoring of their fluid status are weighed according to medical directives.

The Assessment Team reviewed medication incidents for the previous 6 months, noting most incidents related to omission of signature or pharmacy packing errors. Medications are administered in accordance with medical practitioner directives and missed medications are identified and reported through incident reporting processes. The service has a medication management policy and procedure that outlines the safe use of medications, including when to report medication incidents and the process to follow. There was also evidence of an education and learning program for care staff who administer medications to consumers.

The Assessment Team reviewed medication charts and packs for recently admitted respite consumers and noted that medication packs and charts matched, and consumers were receiving medication per the medical practitioner’s directive.

With consideration to the available information summarised above, I find Requirement 3(3)(b) Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Consumers were satisfied with the variety, quality and quantity of meals provided. Consumers confirmed they are consulted about their individual preferences with staff and management supporting their choices.

Where a consumer has decided on an alternate meal preference, this information is referred to clinical staff to ensure options meet with dietary requirements before forwarding to the kitchen.

Staff demonstrated knowledge of consumer food allergies, intolerances, meal choices and preferences. A review of care documentation reflected consumer dietary requirements, preferences, and allergies.

The Assessment Team observed consumers in the dining room interacting with each other, and staff were assisting those consumers that required feeding or supervision.

The service has feedback mechanisms in place which allow consumers or representatives to provide feedback. This was demonstrated by the chef who acknowledged previous complaints about food not being hot when delivered to consumer rooms as well as long wait times for meals served in the dining room. Changes following feedback from the food focus group and resident meetings include new hot pellets under plates and improved insulated plate covers, as well as rotation to table service times.

With consideration to the available information summarised above, I find Requirement 4(3)(f) 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

Consumers were satisfied with the process to resolve complaints or feedback and confirmed issues were followed up and discussed with service personnel.

The Assessment Team noted that some care staff were unfamiliar with the specific term ‘open disclosure’; however, when prompted, they indicated they would refer incidents to the nurse in charge. Clinical staff demonstrated understanding of and when to apply the principle of open disclosure and open disclosure toolbox sessions have recently been provided.

Management described using open disclosure principles when handling complaints, including working collaboratively with consumers and representatives and apologising when necessary. They demonstrated how they consider complaints as an opportunity for improvement which has resulted in the purchase of new equipment to keep food warm and changes to plating and food presentation.

A review of the complaint register identified information regarding sources of complaints, discussion with complainants, action taken, resolution and apologies. Complaints were closed following evaluation by management that the consumer was satisfied with the resolution.

With consideration to the available information summarised above, I find Requirement 6(3)(c) Compliant.

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)