Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Goodhew Gardens |
| Service address: | 2 - 28 Alexander Avenue TAREN POINT NSW 2229 |
| Commission ID: | 0697 |
| Approved provider: | Anglican Community Services |
| Activity type: | Assessment Contact - Site |
| Activity date: | 14 December 2022 |
| Performance report date: | 10 January 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 Goodhew Gardens (**the service**) has been prepared by G Cherry, 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 5 January 2023
* Performance Report dated 24 February 2021 for assessment contact visit 19 January 2021

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **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** |
| **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 3

|  |  |  |
| --- | --- | --- |
| 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)(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

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of the seven specific requirements have been assessed and found compliant.

Requirement 3(3)(a)

A decision was made on 24 February 2021 that the service was non-compliant in requirement 3(3)(a) after a site assessment conducted 19 January 2021. The service was unable to demonstrate that each consumer gets safe and effective personal and clinical care, especially in relation to skin integrity, wound management and pain management.

At an Assessment Contact conducted 14 December 2022 the Assessment Team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* Staff education and training requiring clinical staff attendance.
* Education workshops for care staff covering clinical care topics, implementation of a ‘Stop and Watch’ tool to identify early signs of deterioration and behavioural concerns. Additional workshops are planned to ensure 100 percent attendance.

Interviewed clinical staff demonstrate knowledge of resources available to support consumer assessment and provision of best practice care. Care staff demonstrate knowledge of identifying signs of pain, deterioration in condition and escalating issues of concern and/or incidents to clinical staff.

Interviewed consumers and representatives consider consumers receive care and services needed (including pain management); a representative expressing satisfaction regarding remediation of management team and noting all areas of concern being addressed.

The service demonstrates effective, appropriate and timely receipt of medications (including pain relief, psychotropic medications), pressure relieving processes, skin integrity/wound management, weight monitoring/management, falls prevention, monitoring and management of complex clinical care needs being addressed. Review of documentation detailed care provision resulted in improved outcomes for some consumers (including a reduction in medications) and referrals to medical officers and specialist providers regularly occurs.

I find Requirement 3(3)(a) is compliant.

Requirement 3(3)(d)

A decision was made on 24 February 2021 that the service was non-compliant in requirement 3(3)(d) after a site assessment conducted 19 January 2021. The service was unable to demonstrate staff recognised and responded to deterioration of consumers’ conditions in a timely manner and were unaware of measures for evaluating consumer’s deteriorating condition.

At an Assessment Contact conducted 14 December 2022 the Assessment Team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* A system of daily review by the care manager of consumers who are identified as being at high risk and weekly review of consumers identified as being at medium risk.
* A review of hospital transfers and post death reviews occurred to identify areas for improvement. The review identified a decrease in falls and a decrease in the trajectory of consumers requiring hospitalisation.
* Staff education and training requiring clinical staff attendance.
* Education workshops for care staff covering clinical care topics, implementation of a ‘Stop and Watch’ tool to identify early signs of deterioration and behavioural concerns. Additional workshops are planned to ensure 100 percent attendance.

Interviewed clinical staff demonstrate knowledge of resources available to support consumer assessment/care provision and care staff demonstrate knowledge of identifying signs of deterioration in condition and the escalation process.

However, the assessment team bought forward evidence changes in 3 consumers’ mental health, physical and/or behavioural condition did not result in staff identifying and responding to concerns in an appropriate and/or timely manner. Issues related to non-evaluation of effectiveness of interventions post fall, escalation in wound deterioration not being appropriately attended, non-identification of changes in skin integrity, mouth care and behavioural activities.

Representative feedback included dissatisfaction with staff not identifying changes in consumer’s condition without representative input, finding the consumer’s room in an unkempt manner, not being informed of consumer’s current status and/or follow-up on issues raised including inaccessibility of staff; although acknowledged recent improvement in some aspects.

The approved provider’s response acknowledges evidence bought forward, however assert issues raised by the assessment team relate to individual instances of care, not a lack of underlying systems and processes. They evidenced immediate response to specific issues raised to ensure safety, health, and well-being of care recipients mentioned, implemented improvement actions to ensure compliance and evidenced additional information to support their view. They contend evidence-based policies/procedures relating to aspects of deterioration or changes to mental health/cognitive or physical function/capacity/condition are accessible to guide staff practices, with compliance supported through clinical supervision, monitoring/trending as key clinical governance mechanisms at both service and organisational level.

Actions include commencement of a weekly pain audit, weekly PRN usage evaluation, weekly clinical risk meeting and monthly pain audit to monitor the evaluation of pain management. The service evidenced self-identification of wound management issues resulted in education/training and increase in monitoring processes and specialist wound care review to ensure compliance prior to the December 2021 assessment contact. In addition, they evidenced regular pain review by medical officer and palliative care team. While acknowledging representative feedback, the service assert issues raised with the assessment team were historical and evidenced staff reporting/addressing concerns prior to the assessment contact, however followed-up to ensure ongoing representative satisfaction.

I am satisfied the service had both self-identified and responded to most issues bought forward by the assessment team and their Continuous Improvement Plan demonstrates planned ongoing monitoring as a method to ensure effectiveness of actions implemented.

I find Requirement 3(3)(d) is 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)