Performance

Report

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| Name of service: | Goondee Aged Care Home |
| Service address: | 13 Jersey Road STRATHFIELD NSW 2135 |
| Commission ID: | 2143 |
| Approved provider: | Rasko Holdings Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 August 2023 |
| Performance report date: | 31 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 Goondee Aged Care Home (**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 29 August 2023
* the Assessment contact- site report dated 25 October 2022
* the Performance report for the Site audit conducted 25 May 2021 to 01 June 2021
* Other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** **Personal care and clinical care** | **Non-compliant** |
| **Standard 8** **Organisational governance** | **Non-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.

* Care and service needs for consumers need to be reviewed regularly to ensure they are accurate.
* Consumers with high impact needs or high prevalence risk need to be effectively managed.
* Organisational governance risk management processes are required to be effective.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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)(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. | Non-compliant |

Findings

**Requirement 2(3)(b)**

Consumers’ care documentation and feedback from interviews with consumers and representatives demonstrated individual consumer’s current needs, goals and preferences were addressed, including the care and preferences for advance care planning and end of life care. Staff confirmed there were discussions with the consumer and their family about a consumer’s end of life wishes when a consumer entered the service, and end of life pathways were completed when a consumer’s condition deteriorates.

Staff confirmed registered nurses recorded end of life, and palliative pathway needs in consumers’ care documentation to inform and guide staffs’ delivery of care. Staff were able to describe the care and service needs of consumers and that they document monitoring and observations using charts and progress notes.

Consumers who did not wish to discuss their end of life needs at the time of entry were asked by registered staff during three monthly care reviews. The service introduced a three monthly schedule calendar that was monitored by the Quality team and provided to registered staff to ensure Advanced care plans were completed.

Actions have been completed to address Non-compliance in this Requirement identified at the Site audit conducted 25 May to 01 June 2021.

Consumers’ assessment and planning needs were scheduled with registered staff each month to ensure their needs, goals, and preferences were documented. Consumers’ care documentation identified consumers’ goals and preferences were documented and were in accordance with the consumer’s needs.

Care planning documentation was sent via email to representatives with requests for any changes in advance of three monthly case conferences. Representatives confirmed this action taken by the service and their involvement in assessment and planning concerning their loved one.

Monthly audits were conducted by the Quality team with a number of compliance questions to identify gaps in assessment and planning. The June 2023 and July 2023 audit reports noted compliance of the consumer’s documentation audited.

Based on the information recorded above, it is my decision this Requirement is now Compliant.

**Requirement 2(3)(e)**

Care and services were not reviewed regularly for effectiveness, when circumstances change, or incidents occurred.

For a named consumer who lives with vascular dementia, specialist directions were not implemented in relation to their medication. The consumer was reviewed by a Geriatrician which resulted in recommendations for psychotropic medication to be reduced. Despite management at the service stating communication from external specialists was discussed at meetings and recorded in the electronic care system, this did not occur for this consumer.

The same consumer was reviewed by a dementia advisory service in June 2021, while recommendations had been uploaded into the service’s electronic care system, changes had not been actioned to the consumer’s assessment and planning documentation, to provide staff with strategies to manage the consumer’s challenging behaviours.

For one named consumer who returned from hospital after experiencing a change to their diagnosis, documentation does not support a checklist was completed to review the goals, needs and preferences for the consumer. Consumer return from hospital checklists were reviewed for other consumers which demonstrated the checklist has not been completed or reviewed by management to ensure it has been completed correctly and changes in care needs actioned, however care provision was not affected.

Two consumers with a shared diagnosis of diabetes did not have diabetic care plans in place. Parameters for acceptable blood glucose levels were not recorded. The recording of diagnosis for one of the diabetic consumers was not noted in the electronic care system or on handover information. Following feedback, management committed to a review of care planning for consumers with diabetes to ensure diabetic management interventions will be included in care planning, this process will be completed by 08 September 2023.

For three consumers who were receiving oxygen therapy there were no recorded strategies in care planning in relation to the cleaning or changing of the oxygen equipment. Following feedback, Management committed to revision of care plans for consumers requiring oxygen therapy to include cleaning and maintenance instructions, this process will be completed by 08 September 2023.

For one named consumer with a weight loss of 5.3kgs in three months, referral did not occur to the dietitian as per the service’s processes.

The service undertook actions to address previous Non-compliance in this Requirement which included recording actions on the plan for continuous improvement.

Actions completed included a root cause analysis was applied to all incidents, including the effectiveness of preventative strategies, and discussed at staff meetings and clinical handover. Monthly registered nurse meetings were established to discuss changes in consumer needs, goals, and preferences. Feedback and discussion of three monthly care plan reviews was discussed at registered staff meetings.

While the above actions were noted to be completed there was ongoing deficiencies in demonstrating that actions and processes had been effective to address previous deficiencies identified under this requirement during the site audit 25 May 2021 to 1 June 2021, care and services have not been reviewed as required to ensure accurate directives are documented to guide staff practice and consumers are referred to specialist services in a timely manner.

The Approved provider in its written response to the findings recorded in the Assessment contact report has accepted the findings of the Assessment Team in the report. The Approved provider has created a spreadsheet with all consumers named in the report and key actions to be taken for the individual consumer to address deficits recorded in the report. Actions have included a review of the schedule of assessment and care plan allocation, a monthly clinical care audit to be conducted for the next three months, 100% review of all end of life assessments, advanced care plans, diabetes management, pain assessments, psychotropic register, medication charts, referral documents, behaviour support plans, diabetic consumers, consumer diagnoses, oxygen therapy, weight loss, and restrictive practices.

The Approved provider provided a plan for continuous improvement to address deficits at a Requirement level, including prioritised actions and planned completion dates. I note actions contained on the plan for continuous improvement will be completed by November 2023.

While I acknowledge the actions the Approved provider has committed to completing, these actions will need time to be implemented and assessed as to their effectiveness. Therefore, it is my decision this Requirement remains Non-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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

Findings

Requirement 3(3)(a)

Clinical care and personal care documentation for consumers requiring management of wounds, diabetes, pain, and skin integrity was reviewed. Documents demonstrated, and consumers, representatives and staff confirmed, consumers were receiving individualised care which was safe and right for them and was based on best practice.

Documentation relating to wound and skin care identified regular reviews by the Medical officer and wound specialist, charting, photographs, and measurements. The service had a Physiotherapist that attended the service three times each week and wounds have improved due to the regular fortnightly attendance by a wound specialist.

Staff were familiar with the service’s policies and procedures and were able to locate their whereabouts in the service’s electronic care system.

Actions have been completed to address Non-compliance in this Requirement identified at the Site audit conducted 25 May to 01 June 2021.

Actions have included the presence of the Clinical Care Coordinator at daily handover, the Clinical Care Coordinator also completes clinical rounds and conducts spot checks to ensure pain was managed effectively. A physiotherapist attended the service three times weekly to undertake consumer pain reviews. External specialists were engaged to complete assessments for consumers with complex clinical and personal care needs. Staff were required to attend pain management training and to continue annual online training relating to pain. Monthly clinical meetings for staff were established and discussions included pain and complex care needs of consumers.

Based on the information recorded above, it is my decision this Requirement is now compliant, and consumers were receiving safe and effective care and services.

**Requirement 3(3)(b)**

The service did not demonstrate effective processes to manage high impact or high prevalence risks associated with the care of consumers subject to restrictive practices. Care documentation did not identify effective management or alternate strategies for consumers subject to restrictive practices.

For one named consumer who had been reviewed by a dementia advisory service to manage their behaviours, pain and falls, strategies provided by the advisory service were not implemented or delivered as part of the named consumer’s care and service needs. There were no alternative strategies recorded to guide staff practice prior to administering psychotropic medication to the consumer. Staff were unable to describe the strategies supplied by the advisory service to assist with the consumer’s care.

For a second named consumer, concerns were raised by their representative regarding the dosage of psychotropic medication due to the drowsiness, dribbling, falls and incoherent nature of the consumer. It was identified despite recommendations made by a Geriatrician in December 2022 to reduce the psychotropic medication this had not occurred. Behaviour support planning for the named consumer did not contain any alternatives prior to administering medication to manage the consumer’s behaviours. Despite a Dementia advisory service and the representative providing advice music soothes the consumer when they are anxious, this was not occurring.

A representative for a third named consumer raised concerns their loved one was placed in the dining room all day. Staff confirmed the consumer was placed at the dining table in a chair as they were at risk of falls and were easier to monitor in the dining room. The representative noted their loved one was often asleep at the dining table when they visited. Behaviour support planning indicated the consumer enjoyed reading newspapers and watching television in their native language and enjoys sitting on the floor. Staff were unaware of these strategies to assist the consumer with their behaviour.

For another consumer at risk of falls, care documentation instructs staff to place the consumer in the dining room for observation to minimise the risk of falls. Management and staff at the service have not identified placing consumers in communal areas for ease of observation does not support effective management of high impacts risks for consumers in relation to falls, nor does it support consumers’ choice to be in other areas of the service including their rooms. A number of consumers were observed throughout the Assessment contact - site sleeping periodically with their head on the dining table. A Falls Action plan identified 11 consumers as high falls risks and these consumers are to be attended to first in the morning then transferred to the common are for breakfast and observation. These strategies do not support the dignity of consumers to make choices about their care and services.

Information recorded on the psychotropic medication register was not accurate. Four consumers were listed with a diagnosis of psychosis but did not have supporting documentation to evidence a diagnosis of psychosis. Following feedback, management produced a revised register with changes to the four consumers’ diagnoses to indicate the consumers had a diagnosis of manic depression. There was no supporting evidence to indicate the consumers had a diagnosis of manic depression. While the service had a process for referring consumers to the Geriatric Outreach Team if they are identified as requiring chemical restraint, this had not occurred for three of the four consumers prescribed chemical restraint.

Actions have been completed to address Non-compliance in this Requirement identified at the Site audit conducted 25 May to 01 June 2021.

Actions have included the creation of a high impact risk register. Consumers with high impact, high prevalence risk were identified in monthly clinical indicator reports, this list was to be displayed in nurses’ stations, however, was not evident during the Assessment contact – site. Incidents were trended and discussed at staff meetings. The physiotherapist was supporting the service by visiting three times per week and conducting falls reviews and functional assessments. Training records indicate a range of education has been provided by the service for staff.

While the above actions have been completed the service is not managing effective high impact high prevalence risk effectively. This is demonstrated by falls risk strategies implemented that do not support the dignity or choice of consumers, inaccurate data recorded on the psychotropic drug register, the absence of individual strategies to support consumers with challenging behaviours. The service was unable to demonstrate chemical restraint was used as a last resort after exhausting other alternative strategies.

The Approved provider in its written response to the findings recorded in the Assessment contact report has accepted the findings of the Assessment Team in the report. The Approved provider has created a spreadsheet with all consumers named in the report and key actions to be taken for the individual consumer to address deficits recorded in the report. Actions have included a review of the schedule of assessment and care plan allocation, a monthly clinical care audit to be conducted for the next three months, 100% review of all end of life assessments, advanced care plans, diabetes management, pain assessments, psychotropic register, medication charts, referral documents, behaviour support plans, diabetic consumers, consumer diagnoses, oxygen therapy, weight loss, and restrictive practices.

The Approved provider provided a plan for continuous improvement to address deficits at a Requirement level, including prioritised actions and planned completion dates. I note actions contained on the plan for continuous improvement will be completed by November 2023.

While I acknowledge the actions the Approved provider has committed to completing, these actions will need time to be implemented and assessed as to their effectiveness. Therefore, it is my decision this Requirement remains Non-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. | Non-compliant |

Findings

The service’s risk management system was not utilised effectively, and staff practices were ineffective in managing high impact or high prevalence risks to consumers in relation to behaviours and restrictive practices.

Consumers with challenging behaviours did not contain strategic interventions to support consumers’ complex and high-risk needs.

Management did not have a shared understanding in relation to restrictive practices relating to chemical, physical and environmental restraints.

Actions have been completed to address Non-compliance in this Requirement identified at the Site audit conducted 25 May to 01 June 2021.

Actions have included the implementation of a risk policy to guide staff in monitoring and responding to risk. An incident form was implemented, and staff received education in relation to the documenting and management of risks. Management advised and evidence confirmed staff had received training in relation to risk management. Management was utilising the Commission’s Serious incident response scheme fact guide together with the online decision tool to ensure the correct reporting of incidents within the required timeframe.

The Approved provider in its written response to the findings recorded in the Assessment contact report has accepted the findings of the Assessment Team in the report. The Approved provider provided a plan for continuous improvement to address deficits at a Requirement level, including prioritised actions and planned completion dates.

In relation to this Requirement, the plan for continuous contains actions including reviewing processes for communication of consumer conditions internally and externally with referral specialists, to identify gaps, amend processes as required and to keep consumers’ nominated representatives informed and updated. Additional training will be provided to staff relating to completing progress notes and relevant information for communication and escalation processes, and utilising effective strategies that are bespoke and individualised for consumer engagement. A review of lifestyle assessments will occur to investigate individualised consumer preferences. Management will monitor compliance of these actions and will report progress at clinical care meetings. The planned completion actions are noted to be completed by October 2023.

While I acknowledge the actions the Approved provider has committed to completing, these actions will need time to be implemented and assessed as to their effectiveness. Therefore, it is my decision this Requirement remains Non-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)