Performance

Report

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| Name: | Goondee Aged Care Home |
| Commission ID: | 2143 |
| Address: | 13 Jersey Road, STRATHFIELD, New South Wales, 2135 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 9 January 2024 |
| Performance report date: | 5 February 2024 |
| Service included in this assessment: | Provider: 210 Rasko Holdings Pty Ltd  Service: 672 Goondee Aged Care Home |

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 Therese Solomon, 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.
* the provider’s response to the assessment team’s report received 24 January 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Applicable |
| **Standard 3** Personal care and clinical care | **Not Applicable** |
| **Standard 8** Organisational governance | **Not Applicable** |

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)(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

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it is regularly reviewing the care and services for effectiveness and when circumstances change or incidents impact on consumers. Management explained there is a schedule for the regular review of care plans, which is delegated to the registered nurses and takes place every three months. Consumers and/or representatives are invited to be part of this evaluation and review, and their participation is recorded in the clinical documentation. In addition, each consumer is reviewed each month through the resident of the day process. These processes are overseen by the care manager.

Care and services are also reviewed when a consumer’s circumstances change, such as following an incident, deterioration of condition, or hospitalisation. Incidents are recorded by the registered nurse on an incident form and reviewed by the care manager and general manager. The consumer representative is informed, an investigation is conducted into the incident and the care plan is updated with relevant interventions.

When consumers return from hospital they are reviewed by the registered nurse. This process is directed by a return from hospital checklist to ensure any changes are noted and the appropriate care is delivered. The checklist includes the clinical observations, contact with the consumer’s representative and medical officer, documentation in the progress notes and update of the care plan, notification of relevant staff, including care staff and kitchen staff, and relevant follow-up appointments made.

Staff described the process for the review of care, updating of clinical documentation, and how they are kept informed of any changes. Consumers and/or representatives confirmed they are satisfied with the care provided and are kept informed when changes to care occur.

Management oversees the process of clinical review through daily handover with the registered nurses, regular meetings, collection and analysis of clinical data, and an audit program which includes clinical care review and clinical documentation. The latest clinical care review audit showed all care plans had been evaluated within the required time frame.

# 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

Consumers and/or representatives stated they were satisfied with the management of their high impact, high prevalent risks. They stated they had been consulted in relation to risk mitigation strategies including the use of restrictive practices. However, care and service documentation for consumers and observations showed deficits in relation to restrictive practices, management of changed behaviours and falls management.

Behaviour support plans reviewed did not consistently include all behaviours exhibited by consumers, strategies to mitigate behaviours were not always implemented and behaviour charting was inconsistent or incomplete.

Management advised falls was identified as their high impact, high prevalent risk. Review of consumers who have had falls showed most consumers were managed appropriately post fall. However, preventive strategies were not consistently attended, and post fall management was not always attended to as per the service’s policies and procedures.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found 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 |

Findings

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The governing body demonstrates it has risk management systems and policies and processes in place to support the management of risks and identify abuse and neglect of consumers. The board has initiated an external specialist service to review all policies and processes to ensure they are based on best practice and meet legislative requirements. Policies and processes are updated in alignment with legislative changes and staff members trained to reflect legislative updates.

Weekly meetings are held by board members and the management team to review risks and create strategies to mitigate high impact or high prevalence risks. The Board has a member with experience in clinical care who evaluates clinical performance through reporting, audits and consumer and staff feedback, and provides recommendations relating to clinical risks and prevention strategies.

Communication of policies and processes to staff members is achieved through a quality manager who provides staff training and audits staff to ensure they have practical knowledge of policies and processes. Staff members demonstrate a good understanding of policies and processes relating to Serious Incident Response Scheme, clinical care, identifying and reporting risks, and supporting consumers to live the best life they can.

Documentation shows policies and processes are updated and in alignment with legislation and best practice. Board and management meeting minutes demonstrate risks and incidents are identified and reviewed, and consumers are supported to live the best life they can.

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)