Performance

Report

**1800 951 822**

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| Name of service: | Gumleigh Gardens Hostel |
| Service address: | 29-35 Shaw Street Wagga Wagga NSW 2650 |
| Commission ID: | 1011 |
| Approved provider: | United Protestant Association of NSW Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 March 2023 |
| Performance report date: | 11 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 Gumleigh Gardens Hostel (**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 30 March 2023, including plan for continuous improvement
* Performance Report dated 14 July 2021

# 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)(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. | Compliant |

Findings

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

Requirement 2(3)(b)

A decision was made on 14 July 2021 that the service was non-compliant in requirement 2(3)(b) after a site assessment conducted 8 to 10 June 2021. The service was unable to demonstrate care plans contain information relevant to the current needs, goals, and preferences of consumers.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* Review/update all care plans to include current information regarding consumers’ condition, goals, needs and preferences
* Implement a process of regular review/auditing of care plans by senior clinicians to ensure currency
* Provide additional staff training in relation to care planning noting the importance of accurate record maintenance.

Documentation review of assessment and care planning documentation for sampled consumers demonstrate consumers’ preferences, goals and needs including end of life (EOL) care are documented to guide staff in care provision.

Requirement 2(3)(e)

A decision was made on 14 July 2021 that the service was non-compliant in requirement 2(3)(e) after a site assessment conducted 8 to 10 June 2021. The service was unable to demonstrate removal of outdated/conflicting information occurs and/or development of strategies to mitigate risks association with changes are included in care planning documentation.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* Implement a system to ensure the electronic care management system (ECMS) alerts staff when a consumer’s care plan is due for review.
* Provide additional staff training in relation to ensuring changes to consumers’ condition results in care plan review.
* Ensuring yearly case conferences with consumers/representatives, medical officers, and clinical staff to review effectiveness of care and service plans.
* Ensure consumers/representatives have knowledge care plans are consistently available/accessible.

Documentation review for sampled consumers demonstrate case conference discussions/updating of documentation has occurred. All sampled care plans have been reviewed within the prior 6 month period with the exception of 3 consumers recently admitted to the service. Review of documentation demonstrate medical officer/specialist review, implementation of directives/changes in care and representative/family involvement in ongoing care. In addition, strategies to support unmet behavioural needs are generally documented in behaviour charts and relevant behaviour support plans (BSP) to guide care delivery (refer to requirement 3(3)(a). Interviewed consumers/representatives’ express satisfaction of communication between medical officer/specialists/clinical staff to ensure they are informed of current care requirements.

# 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)(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 14 July 2021 that the service was non-compliant in requirement 3(3)(a) after a site assessment conducted 8 to 10 June 2021. The service was unable to demonstrate that each consumer gets safe and effective personal and clinical care, especially in relation to use of psychotropic medications, wound photography, and pain management, consistent with best practice guidelines and recommendations.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance.

The service demonstrate effective systems to ensure best practice care provision for consumers in relation to wound and pain management. Interviewed consumers/representatives’ express satisfaction of clinical care provision and representatives’ express satisfaction regular communication received from staff in relation to consumer’s care needs.

The assessment team observed sampled consumers receiving care aligned with directives in care planning documentation. For example, dressing regimes as per wound care specialist directives, wound charts containing wound photography/measurements, pain monitoring attended to prior to dressing of wounds and non-pharmalogical methods of pain relief. A review of one consumer’s pain monitoring/management chart note inconsistent recording of pain levels and lack of regular notation when pain is monitored. In their response the approved provider noted the sampled consumer’s pain levels require recording in an ‘as needs’ basis and demonstrate regular review by medical officer/specialist teams resulting in a new pain management regime which subsequently reduced pain levels. Staff education/training has occurred with a plan for repeat sessions to ensure all staff have completed training.

Via documentation review the assessment team noted 2 consumers being administered antipsychotic medication without a medical diagnosis to support this use. As such administration of medications is being used to address unmet behaviours without appropriate completion of documentation within a BSP, noting use as a restrictive practice. One file demonstrates medical officer discussion and authorisation of use (and understanding of risks) however recorded in an alternate area. As such, antipsychotic medications are being administered without the service meeting legislative requirements. Management acknowledge deficits in required documentation and committed to ensuring immediate rectification.

In their response the approved provider researched medications being used, reviewed relevant policy guidance relating to completion of BSP’s and Behaviour Management policy, noted a contradiction between the two (requiring amendment), consulted with medical officers and representatives and amended consumer’s documentation. In addition, a review of all consumers BSP’s and medication authorisation documentation was conducted to ensure appropriate completion; plus, education sessions commenced for clinical staff. They note self-identification and implementation of staff education as a continuous improvement activity had resulted in improved consumer outcomes.

In recognising organisational policies/procedures require updating, they advised of reviewing/contextualising externally sourced policies with a planned implementation to guide staff once endorsed by the Clinical Governance Committee.

I am swayed by the service’s immediate (and planned actions as a result of self-identification) plus results of their internal review identified required documentation in place for most consumers. I am satisfied the service has systems to attain compliance.

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

Requirement 3(3)(d)

A decision was made on 14 July 2021 that the service was non-compliant in requirement 3(3)(d) after a site assessment conducted 8 to 10 June 2021. The service was unable to demonstrate acute onset of pain and deteriorating mental health was captured in clinical documentation or escalated in a timely manner for each consumer.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* Implementing a process of management personal having an increased presence to ensure stronger clinical oversight.
* The clinical nurse specialist attends shift handover discussions to be alerted to any consumers’ deteriorating condition and/or ensure follow-up occurs relating to outstanding care issues.
* Management meet daily with occupational therapist/clinical staff to discuss ‘at risk’ consumers resulting in accessibility to immediately identify changes to consumer’s needs.
* Implemented a policy relating to ‘deterioration/change to consumer’s condition’ to guide staff on identifying/responding/managing clinical and/or mental health deterioration.

Documentation review for sampled consumers demonstrate effective identification/response and management of changes to consumer’s condition and escalation to appropriate medical officer/allied health specialist to enable clinical care provision. The assessment team observed sampled consumers receiving care in alignment with care directives. Interviewed consumers/representatives’ express satisfaction of referral to clinical staff and medical officer/specialists to ensure consumer’s needs are met.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

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

Requirement 7(3)(a)

A decision was made on 14 July 2021 that the service was non-compliant in requirement 7(3)(a) after a site assessment conducted 8 to 10 June 2021. The service was unable to demonstrate effective workforce deployment to ensure safe/quality care provision consistently occurs.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance which include:

* Ensuring a registered nurse is on site at all times.
* Implementing a system (‘resource to risk’ approach) of allocating appropriate staff numbers in response to current consumer cohort needs. For example, an additional staff member allocated to the dementia specific wing during times when consumers’ express unmet behavioural needs (late afternoon/evening).
* The care manager and clinical nurse specialist (both registered nurses) provide clinical and personal care when required.

Interviewed consumers and staff express satisfaction staffing numbers/skill mix is adequately maintained and managed effectively to enable delivery and management of safe, quality care and services. Three sampled consumers said their needs are met in a timely manner and all interviewed staff said they have sufficient time to complete required duties. Management advised due to an overall shortage of personnel throughout the region, the organisation has an on-going recruitment action for clinical and care staff.

Document reviews demonstrate sufficient staff as per identified requirements however 2 evenings where a registered nurse was not on site. It was however noted, alternative strategies of contacting a registered nurse from a sister service and/or care manager/clinical nurse supervisor attending to provide clinical support when required.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management. 2. continuous improvement. 3. financial governance. 4. workforce governance, including the assignment of clear responsibilities and accountabilities. 5. regulatory compliance. 6. feedback and complaints. | Compliant |

Findings

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

Requirement 8(3)(c)

A decision was made on 14 July 2021 that the service was non-compliant in requirement 8(3)(c) after a site assessment conducted 8 to 10 June 2021. The service did not demonstrate effective governance systems in relation to information management, continuous improvement, and regulatory compliance.

At an Assessment Contact conducted 8 March 2023 the assessment team bought forward evidence the service has implemented actions in response to the previous non-compliance.

Effective governance systems in relation to information management, continuous improvement, and regulatory compliance is evident.

Information management

Management explained the system of board members disseminating information to staff and consumers through a variety of methods. Interviewed staff note they have readily available access to consumer information, policies/procedures, and resource material via an electronic case management system and paper-based folders.

Continuous improvement

Management explained how continuous improvement opportunities are identified from a variety of sources, including consumer/representative feedback/complaints mechanisms, regular analysis of clinical/incident data, internal audits, and identification of deficiencies relating to staff knowledge/practice. An example includes consumer feedback of satisfaction in provision of a specialised wheelchair. The assessment team observed management regularly updating the service’s Plan for Continuous Improvement to reflect feedback received.

Financial governance

Management are provided with a budget to enable daily expenditure and high value projects, which is regularly discussed with organisational managers. Interviewed staff express satisfaction with sufficient equipment and training support.

Workforce governance

The service has a workforce governance framework in place to ensure staff are sufficiently skilled/qualified and sufficient numbers of staff to provide consumers with safe, respectful quality care and service. An organisational chart outlines staff accountabilities and responsibilities.

Regulatory compliance

Organisational processes monitor/communicate legislative changes and update relevant policies/processes. Information is provided on a regular basis and when changes occur. Documentation demonstrate training and education for staff in line with ongoing legislative changes. Recent updates include reporting requirements relating to the Serious Incident Response Scheme and Worker Code of Conduct. Deficits were noted at the service level in relation to recording of restrictive practices for 3 consumers (considered in requirement (3)(3)(a).

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)