Performance

Report

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| Name of service: | Haddington Nursing Home |
| Service address: | 126 Duncan Street TENTERFIELD NSW 2372 |
| Commission ID: | 0569 |
| Approved provider: | Tenterfield Care Centre Limited |
| Activity type: | Assessment Contact – Site |
| Activity date: | 29 September 2022 |
| Performance report date: | 9 November 2022 |

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 Haddington Nursing Home (**the service**) has been prepared by T Wurf, 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 26 October 2022
* the Performance Report dated 5 April 2022 following a site audit undertaken 15 February 2022 to 17 February 2022.

# 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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **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

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.

* Requirement 3(3)(a) – Consumers receive safe and effective clinical care, including in relation to the management of restrictive practices and falls.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| 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. | Not assessed |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Not assessed |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not assessed |
| 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. | Not assessed |

Findings

The performance report dated 5 April 2022 found the service non-compliant with requirement 2(3)(a). Deficiencies related to assessment and care planning processes in relation to the use of restrictive practices.

The Assessment Contact Report identified that the service has taken improvement actions to address the non-compliance and improve its performance in this requirement. Actions included:

* staff training in the use of the electronic care management system to ensure documentation and assessments are completed correctly
* updating policies and procedures relating to restrictive practices
* allocation of restrictive practices as a ‘portfolio’ responsibility to a registered staff member who ensures legislative requirements are completed and reviewed.

Consumers and their representatives reported they are involved in, and satisfied with, the assessment and care planning processes at the service. A representative described risks identified for a consumer, the assessment undertaken by an allied health professional and the subsequent adjustment of care.

Consumers’ care documentation reviewed by the Assessment Team identified consumers’ needs, goals, preferences and any risks associated with their care. Risks included complex behaviours, diabetes and wounds.

Management and staff described how assessment and planning are undertaken with consumers, initially before the consumer enters the service and ongoing during their time at the service. These processes inform the development of an individualised care plan.

The service has policies and procedures that guide staff in assessment and planning.

Based on the Assessment Contact Report and the improvements made by the service, I am satisfied that assessment and planning processes include consideration of risk and inform the delivery of safe and effective care. Therefore, I find requirement 2(3)(a) is now 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not assessed |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not assessed |
| 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. | Not assessed |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not assessed |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not assessed |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The performance report dated 5 April 2022 found the service non-compliant with requirements 3(3)(a) and 3(3)(g). Deficiencies related to the service’s failure to adequately manage restrictive practices in line with legislative requirements and ineffective processes to manage infection-related risks (including COVID-19).

*Requirement 3(3)(a)*

The Assessment Contact Report identified ongoing deficiencies in the service’s management of restrictive practices (chemical restraint) as well as falls management.

Whilst the service had implemented effective improvements that addressed deficiencies relating to assessments, monitoring and use of mechanical restraint (bed rails), the service was not consistently meeting legislative requirements in relation to the management of chemical restraint. For example:

* In relation to informed consent, the risks and benefits associated with the use of psychotropic medication as a form of chemical restraint had been discussed with most, but not all, consumers and/or their representatives.
* Whilst restrictive practice risk assessment and authorisation forms were in place for most, but not all consumers, these had been signed by a registered nurse rather than a medical officer or nurse practitioner as required by the *Quality of Care Principles 2014*.

Additionally, whilst the organisation had a falls management policy and flow chart available to staff which registered staff were familiar with, the management of consumers who experienced a fall was inconsistent; the frequency of physical and neurological observations and follow-up assessments were not consistently completed for three named consumers.

The approved provider’s response to the Assessment Contact Report identified improvement actions to address the deficiencies, including:

* Updating policies and various processes, procedures and forms relating to the management of restrictive practices and falls to ensure the service meets legislative requirements and best practice guidelines.
* Comprehensive review of all consumers receiving psychotropic medication and subject to chemical restraint and those consumers who had experienced falls. Relevant actions have been taken or planned to address gaps or deficiencies.
* Training in restrictive practices and falls management for registered and enrolled nursing staff in the updated policies and procedures and legislative requirements.
* Establishing monitoring processes to ensure compliance with updated policies, procedures and processes for chemical restraint and post-fall management
* Established a falls management and prevention committee.

As identified above, the service has commenced actions to address the deficits identified in the management of chemical restraint and falls. I acknowledge the commitment of the approved provider; however, these improvement activities are either recently implemented or have not been completed and therefore have not been tested for effectiveness or sustainability.

It is my decision that, at the time of the Assessment Contact visit, the service’s clinical care was not safe and/or effective in relation to these areas. Therefore, requirement 3(3)(a) remains non-compliant.

*Requirement 3(3)(g)*

The service has policies, procedures and an outbreak management plan to ensure infection-related risks are minimised and to guide staff in antibiotic use, infection control and management of outbreaks such as COVID-19

The service has a dedicated infection control and prevention lead role and provides a vaccination program for staff and consumers. Antibiotic usage is reported, monitored and discussed at monthly infection control meetings.

The Assessment Team observed staff using personal protective equipment and performing hand hygiene appropriately.

Staff provided examples of practices to prevent and control infections such as hand hygiene, encouraging fluids, and the use of personal protective equipment.

I am satisfied the service has taken improvement actions to address the non-compliance and improve its performance in requirement (3)(3)(g). Actions included:

* engaged a designated Infection Prevention and Control Lead who monitors the service’s infection control processes and facilitates training and education
* updated the service’s Outbreak Management Plan
* staff education on infection control topics including appropriate use of PPE, hand hygiene and effective cleaning
* establishing procedures to:
  + screen visitors and staff upon entry to the service aligned with state government requirements
  + monitor the temperature of the medication and specimen fridge to ensure the refrigerators maintain the correct temperature. This has been added to the service audit monitoring program
  + regularly clean consumers’ trays. This forms part of the auditing program to ensure compliance

Based on the Assessment Contact Report and the improvements made by the service, it is my decision that requirement 3(3)(g) is now compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Not assessed |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not assessed |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers/representatives commented positively about the furniture, equipment and cleanliness of the service, including the outdoor areas. They reported that maintenance staff attend to anything that needs repair.

Cleaning and maintenance are scheduled and monitored daily, with equipment used by consumers regularly serviced and maintained. The service documents and actions preventative and reactive maintenance and cleaning.

The Assessment Team observed the service to be well maintained, clean and safe.

The performance report dated 5 April 2022 found the service non-compliant with requirement 5(3)(c). Deficiencies related to the service’s use of bed rails for some consumers that were unsafe, inappropriate and ill-fitted. I am satisfied the service has taken improvement actions to address the non-compliance and improve its performance. Actions included:

* Conducted a full audit of all consumer beds to ensure the correct fitting of bed rails.
* Removal of bed rails not supported by a risk assessment and authorised restrictive practice documentation.
* Replacement of all mattresses on consumer beds where bed rails were in use to ensure there were no gaps between the rail and mattress.
* Completed risk assessments and restrictive practice authorisations for those consumers with bed rails in place. Consumers confirmed that registered staff had spoken to them about the risks associated with bed rails.
* Auditing the correct use and fitting of bed rails at the service as part of the service’s audit program.

Based on the Assessment Contact Report and the improvements made by the service, it is my decision that requirement 5(3)(c) is now compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not assessed |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not assessed |
| 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 |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The performance report dated 5 April 2022 found the service non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(c). Deficiencies related to ineffective governance systems (continuous improvement and regulatory compliance), risk management systems (relating to restrictive practices) and clinical governance systems (relating to restrictive practices and infection control).

*Requirement 8(3)(c)*

The Assessment Contact report identified actions implemented to improve governance systems relating to continuous improvement and regulatory compliance were ineffective and/or unsustainable. Specifically, the service’s continuous improvement system has been ineffective in addressing ongoing deficiencies in relation to the management of restrictive practice (chemical restraint) and non-compliance with requirement 3(3)(a), and, as a result, the service is still not meeting its legislative responsibilities in managing restrictive practices. I have addressed these matters under requirement 3(3)(a) I do not consider they are generally reflective of an ineffective governance system.

Additionally, the approved provider’s response included evidence that the deficiencies relating to chemical restraint had been rectified (refer to requirement 3(3)(a)), a robust plan for continuous improvement was in place and additional monitoring processes had been established to ensure legislative responsibilities were maintained and improvements are implemented, effective and sustainable.

Based on the Assessment Contact Report and the approved provider’s response, I am satisfied the approved provider has effective governance systems in place. It is my decision that requirement 8(3)(c) is now compliant.

*Requirement 8(3)(d)*

The Assessment Contact Report identified that the service has established governance frameworks, policies and procedures to support the management of risk associated with the care of consumers, including responding to clinical incidents. Management and staff provided examples of the key risks to the consumer cohort and how risks are managed.

Incidents are managed through the electronic incident management system. The service identifies, responds to and reports incidents, including serious incidents through the Serious Incident Response Scheme (SIRS). The service has policies and procedures in relation to incident reporting and staff understand their responsibilities to report incidents.

I am satisfied the service has taken improvement actions to address non-compliance in requirement 8(3)(d). Actions included

* training by an external training organisation for the Facility Manager and a registered nurse in identifying high impact risks for consumers
* recruitment of a communication and education coordinator to manage staff training records management system and monitor staff participation in training such as incident management and SIRS
* implementation of an improved incident reporting tool that requires follow-up action and investigation to mitigate risk of reoccurrence
* creation of a Leadership and Governance committee that meets monthly to report and discuss clinical data, complaints, and incidents
* an audit program, that includes among other things, the correct use and fitting of bed rails.

Based on the Assessment Team’s findings and the improvements made by the service, it is my decision that requirement 8(3)(d) is now compliant.

*Requirement 8(3)(e)*

The Assessment Contact Report identified that the organisation had effective clinical governance, including in relation to antimicrobial stewardship and open disclosure. Improvement actions had been implemented to address the non-compliance in relation to requirement 8(3)(e), including in relation to the use and monitoring of mechanical restraints (bed rails) and infection control prevention and management. These improvements are identified above under requirements 3(3)(g) and 5(3)(c).

However, the Assessment Contact report identified ongoing deficiencies in relation to clinical governance systems that related to restrictive practices (chemical restraint) and clinical care (post-falls management). These matters have been addressed above under requirement 3(3)(a) and I do not consider they are generally reflective of an ineffective clinical governance system.

Additionally, the approved provider’s response included evidence that the deficiencies relating to chemical restraint and post-fall management have been addressed and identified that clinical governance reporting had been reviewed and strengthened.

Based on the Assessment Contact Report and the approved provider’s response, I am satisfied the approved provider has effective governance systems in place. It is my decision that requirement 8(3)(e) is now 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)