Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Hakea Grove Aged Care |
| Commission ID: | 1036 |
| Address: | 102 Louisiana Road, HAMLYN TERRACE, New South Wales, 2259 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 16 September 2024 to 17 September 2024 |
| Performance report date: | 1 November 2024 |
| Service included in this assessment: | Provider: 2926 Hakea Grove Aged Care Pty Limited  Service: 6808 Hakea Grove Aged Care |

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 Hakea Grove Aged Care (**the service**) has been prepared by M.Wyborn, 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, and
* the provider’s response to the assessment team’s report received 4 October 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not compliant |
| **Standard 7** Human resources | **Not applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements were 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.

**Requirement 3(3)(a)** - implement effective systems to ensure consumers receive best practice clinical care tailored to their needs and optimising health and well-being. In particular relating to managing behaviour, mechanical restraint and environmental restraint.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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 service demonstrated safe and effective delivery of consumer clinical care in relation to diabetes management, weight loss, catheters, wounds and bowels. Consumers’ personal hygiene is tailored to their needs and consumers and representatives advised they are satisfied with the clinical and personal care delivered by the service. The Assessment Team reported however, that the service was unable to demonstrate consistent management of the impact of pain for consumers with changed behaviours or understanding of restrictive practices, specifically environmental and mechanical restraints, to ensure the provision of safe and effective care. In their response to the Assessment Team Report, the Approved Provider supplied a written response to the report findings, their Action Plan for October 2024 and associated documents to support their efforts to support compliance with Requirement 3(3)(a). These included their organisational chart, Behaviour Support policy, Restrictive Practice Minimisation policy and restrictive practice monitoring form, and staff training records. The Approved Provider demonstrated that the service has undertaken review and assessment of the consumers mentioned in the Assessment Team report and the service has delivered a restructure of their services management line to ensure that the assistant director of nursing maintains responsibility of clinical oversight with the support of a clinical care coordinator. The service has employed two clinical staff in their education team and a quality and compliance manager to support targeted clinical education to staff.

The Approved Provider highlighted that when a consumer experiences changes in behaviour, a Confusion Assessment Method (CAM) and delirium screen are attended as a routine investigation. The service undertakes assessment of pain via the abbey scale, consider recent medication changes, effects of constipation and presence of infection. When interventions are required to manage a consumer’s pain, the planned and agreed interventions are implemented and the service demonstrated that prior to psychotropic medications being administered, multiple nonpharmacological interventions are attempted in line with the consumer’s strategies and behaviour support plan. The Approved Provider demonstrated that consumers are comprehensively assessed upon admission, and care plans are regularly reviewed and assessed. The Approved Provider highlighted that toolbox talks are currently being delivered to care staff on pain and the impact on consumer behaviours, with a focus on reviewing and documenting the effectiveness of all non-pharmacological interventions, and this education is ongoing. While pain is being identified as a changed behaviour, the service’s response does not demonstrate that consumer pain is regularly assessed and monitored in connection with changed behaviours. The service was unable to demonstrate that staff are exhausting all best practice alternatives, including person-centred behaviour support and consideration of pain, prior to use of chemical restraint. Further, the service did not demonstrate that staff are considering underlying causes/triggers of changed behaviour or that pain is effectively assessed and monitored in accordance with the expected standard of practice.

In relation to environmental restraint, the Approved Provider highlighted their continuous improvement action plan to review the service’s after hours entry and exit processes and consider the option of keypad access into the facility after hours. At this time, if consumers wish to leave the facility after sunset and before sunrise, they are free to do so, however, the access back into the facility during these times is restricted as the doors are locked for security purposes. Consumers are required to press the buzzer at the front door to call staff to open the door to let them back into the facility. In relation to mechanical restraint, the Approved Provider advised that the service routinely obtains consent for all consumers who use bedrails, regardless of whether this is a consumer personal request or not. The service has undertaken to review their restrictive practice guidelines, and the Approved Provider highlighted in their response that all consumer consents are up to date. While I acknowledge the Approved Provider’s corrective actions, the service did not demonstrate a consistent and correct understanding and identification of practices or interventions used at the service that are a restrictive practice (for example: environmental restraint and mechanical restraint) in accordance with the Quality of Care Principles 2014 (the Principles) definitions and types of restrictive practices. Nor did the service's policy align with definitions of each type of restrictive practice in accordance with the Principles. Additionally, the service was unable to demonstrate that they conduct individualised and ongoing assessments and reviews for each consumer which considers if practices or interventions may be a restrictive practice to ensure restrictive practices are used only as necessary and in accordance all requirements set out in the Principles.

The Approved Provider’s response demonstrates that further time and action is required to implement, embed and evaluate the service’s response. As such, at this time, I provide greater weight to the Assessment Team’s information in relation to care that is best practice, tailored to individual consumer needs, and optimises their health and well-being. Therefore, I find the service non-compliant in Requirement 3(3)(a).

The service demonstrated effective processes to manage high impact or high prevalence risks associated with consumer care such as choking, weight loss, skin integrity, behaviours and falls. Consumer clinical indicator data is appropriately used to identify high impact and high prevalence risks. The service maintains a consumer high impact high prevalence risk register and the CEO and assistant director of nursing advised that the service’s current high impact, high prevalence risks are falls, pain management and psychotropic medication and behaviours. The Assessment Team reported that consumer documentation demonstrates that the service is effectively managing high impact and high prevalence risks. Consumers who are at risk of falls or who have fallen are monitored and reviewed by clinical staff and or allied health professionals. Consumer falls incident reports are routinely documented and consumers are reviewed following a fall and appropriate risk mitigation strategies are implemented to best support the consumer. Consumers who have experienced unintentional weight loss, the service demonstrated routine identification, assessment and implementation of strategies for individual consumers based on their needs. This includes supplements, dietician and or speech pathology reviews. The service demonstrated appropriate use of food and fluid charts for consumers who are at high risk of unintended weight loss to facilitate increased clinical oversight of the consumer.

With these considerations, I find the service compliant in Requirement 3(3)(b).

The service demonstrated that consumers who have experienced a deterioration or change in their cognition, condition, function and/or mental health have their needs recognised and responded to in a timely manner. The registered nursing staff routinely liaise with the assistant director of nursing and with the consumer’s medical officer when a consumer’s care deteriorates. The service’s clinical nurse consultant supports staff in conjunction with the assistant director of nursing when a consumer’s cognition or behaviours deteriorates or changes. The service demonstrated appropriate and timely communication and consultation with consumers and their representatives when there are changes or deterioration in a consumer’s health. The service also demonstrated that consumer planning documentation and/or progress notes reflect identification and response to deterioration or changes in individual consumer’s function, capacity or condition.

With these considerations, I find the service compliant in Requirement 3(3)(d).

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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 service demonstrated a workforce that is planned to enable management and delivery of safe and quality consumer care and services. The service demonstrated deployment of sufficient staff with appropriate skills rostered across shifts in line with their master roster. The service utilises agency staff to fill the roster when required to mitigate short staffing. To ensure that consumer needs are met, the service rosters two additional staff for five hour shifts on the morning and afternoon rosters. These staff back-fill shifts as required. Consumers and representatives advised that consumer needs are routinely met in a timely manner. The service has recently introduced the role of assistant director of nursing who has responsibility for clinical oversight and the services has reviewed the role of quality/education manager to better align the two separate functions of the role. The CEO, assistant director of nursing and the human resources management team maintain oversight of the service’s culture and performance management processes.

With these considerations, I find the service compliant in Requirement 7(3)(a).

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

The organisation demonstrated that the service routinely escalates risk to the board. The organisation administers an effective incident management system where the CEO escalates critical and high-risk incidents and risks to the chairperson of the Board when they are identified. The CEO directs the investigation of these types of incidents/risks and provides regular progress reports to the Board. The CEO highlighted that this escalation and oversight is supported by the organisations clinical governance framework.

The assistant director of nursing clinical report and reports from the clinical advisor to the board form part of the organisational risk management oversight by the board. The CEO advised the Assessment Team that the organisational Board operated on a low risk tolerance. The organisation’s clinical risk, financial risk and organisational workforce risks are currently the 3 high impact and high prevalence risks for the organisation and service.

The organisation demonstrated effective systems for identifying and responding to abuse and neglect of consumers via their clinical governance framework and their incident management reporting systems. The organisation supports consumers to live the best life they can as part of their core values and this is routinely monitored via through the organisation’s dignity of risk processes, and data from complaints, incidents and surveys.

With these considerations, I find the service compliant in Requirement 8(3)(d).

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)