Performance

Report

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| Name: | HammondCare - Bond House |
| Commission ID: | 0083 |
| Address: | Judd Avenue, HAMMONDVILLE, New South Wales, 2170 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 13 February 2024 to 15 February 2024 |
| Performance report date: | 9 April 2024 |
| Service included in this assessment: | Provider: 749 HammondCare  Service: 99 HammondCare - Bond House |

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 HammondCare - Bond House (**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 13 March 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 5** Organisation’s service environment | **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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement 1(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.

Consumers and/or representatives consistently reported they are treated with dignity and respect. Care plans generally have information that is consistent with the consumer's identity and culture, and interactions with consumers were observed to be respectful and caring. Consumers and/or representatives stated that all staff and management are approachable, listen to their concerns, and they are treated with dignity and respect.

Documentation reviewed, such as care plans and progress notes, showed staff write about consumers in ways that indicated respect and understanding of their personal circumstances. Other care and service documents reviewed reflected the diversity of consumers. Documentation, including strategic plans and diversity plans, outlined what it means to treat consumers with respect and dignity.

Staff were observed interacting with consumers respectfully and with care, this included during mealtimes and a birthday celebration organised by the service for a consumer, where the consumer’s family and friends were invited and celebrated with the consumer at the service.

# 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. | Compliant |
| 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. | Compliant |
| 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. | 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 Assessment Team identified areas for improvement related to assessment and planning documentation. The Assessment Team found risks to consumers were not consistently identified, and interventions were not always implemented to manage risks, which could result in negative outcomes for consumers. While staff were able to explain how they use assessment and planning for the delivery of safe and effective services, this was not consistently demonstrated through the review of the clinical documentation.

During the Assessment Contact it was reported that the services was in the process of transitioning to an electronic care system, and once fully implemented the electronic care system will streamline the documentation process and improve capturing consumer needs as well as individualised care and services. Utilising an electronic care system will reduce the need to document information in multiple sources and increase effectiveness with communicating consumer needs, goals, and preferences in relation to care and services.

The Approved Provider responded with additional documentation and actions implemented to address the identified non-compliance, including but not limited to completing the transition to an electronic care system, review of identified consumers files, and creating alerts in the electronic care system to prompt staff to complete clinical indicators.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(a) is found Compliant.

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

Consumers and/or representatives confirmed they are given the opportunity to discuss their care needs, goals, and preferences, including advance care directives or end-of-life planning. A review of care and service documents detail what is important to each consumer and how they want their care delivered. End-of-life care plans were noted to be in place for consumers.

Consumers and/or representatives stated they discussed end-of-life preferences with the service and have provided copies of their advanced care directive to the service to be kept on file. Consultation between consumers and/or representatives was evident in consumers care files.

Management and registered nurses advised that the conversation about advance care planning starts during the admission process or later if preferred by the consumer. Advance care and end-of-life planning discussions are also raised during case conferences if considered appropriate. Care staff and homemakers demonstrated an awareness of consumers' needs and stated they would refer to the consumers' care plans and registered nurses if they required more information.

Requirement 2(3)(c) 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 there are processes in place to ensure assessment and planning are based on an ongoing partnership with consumers, the people they wished to be involved in their care and other organisations and providers of care. Care documentation provided evidence of case reviews, involvement of the consumers and others they wished to be involved with, and the involvement of other health providers such as dietitians, speech pathologists, and wound consultants. Consumers and/or representatives confirmed they are involved in their care planning.

Requirement 2(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 service-demonstrated outcomes of assessment and planning are effectively communicated to the consumer and/or representative and is documented in a care and services plan that is readily available to consumers. Care documentation showed discussions around care have been occurring, and consumers and/or representatives confirmed they had been involved in case conferencing and had been provided with a copy of their care plan. Staff explained how they keep the consumers and representatives updated with any changes.

The service uses a paper-based documentation system to record all documentation and type and print care plans to put into folders. Care plans were readily available to consumers and/or representatives.

The Assessment Team identified areas for improvement in relation to the documentation of the review of care and services. The service demonstrated investigations of incidents occur, however documentation did not consistently evidence the comprehensive investigation of incidents.

The Approved Provider responded with additional documentation and actions implemented to address the identified non-compliance, including but not limited to completing the transition to an electronic care system, review of identified consumers files, and creating alerts in the electronic care system to prompt staff to complete clinical indicators.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found 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. | 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 |
| 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. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| 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

Consumer and/or representative feedback regarding clinical and personal care was mostly positive, and staff knowledge of consumer care needs was sound. However, The Assessment Team identified areas for improvement in relation to documentation for various areas, including pain management, falls management, diabetes management and behaviour support plans.

A review of the care documentation for consumers requiring pain management showed lack of documentation to demonstrate the consideration of pain during the provision of wound care, and evaluations of pain management strategies implemented are not consistently documented.

The Assessment Team identified lack of documentation to demonstrate strategies in the behaviour support plan for a consumer are consistently followed prior to the use of high-risk psychotropic medications. Behaviours are not charted accordingly, and other reasons for consumers' change of behaviour are not always explored, such as pain or natural reaction to an incident that may cause anxiety due to their deteriorating condition.

The Approved Provider responded with additional documentation and actions implemented to address the identified non-compliance, including but not limited to completing the transition to an electronic care system, review of identified consumers files, and creating alerts in the electronic care system to prompt staff to complete clinical indicators.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found Compliant.

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

Consumers and/or representatives stated consumers get the care they need, and they are confident they are receiving the care they should be getting. They stated the service investigates incidents promptly, and they are consulted and informed of the strategies that will be put in place to prevent or reduce the incidents from happening again.

Information derived from assessments and care planning documents showed high impact and high prevalent risks associated with the care of consumers are managed appropriately to reduce or prevent the risks that affect the consumers' health and wellbeing. The service records high-impact and high-prevalence clinical and personal risks for consumers through their clinical risk register and incident reports. Data is analysed and discussed at the daily, weekly, and monthly clinical staff huddles and meetings.

Requirement 3(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 service demonstrates that deterioration or change of consumers' mental health, cognitive or physical function, capacity, or condition is recognised and responded to in a timely manner. A review of care documentation of consumers who experienced deterioration showed that escalation and response to deterioration processes had been identified or recognised in a timely manner. Consumers and/or representatives provided positive feedback regarding the service's effectiveness in responding to deterioration in a consumer's condition.

Consumers and/or representatives provided positive feedback regarding the service's response when consumers experience deterioration or changes to their health. They stated the staff and management are responsive when a consumer becomes unwell and notify them of the changes as they occur.

Consumers who have experienced unplanned weight loss and general deterioration, the Assessment Team identified consumers were reviewed and assessed by staff according to their deterioration policy and guidelines. Consumers were referred to the dietitian and the speech pathologist, have been assessed accordingly, and have been prescribed nutritional supplements. Appropriate food texture and fluid thickness are applicable for the consumer and recorded in the care plans. The food and fluid charts are updated by staff accordingly.

Documentation confirmed that the registered nurse investigates the identified deterioration in a consumer's cognitive or physical health status, and the consumer is referred to their medical officer and/or an appropriate health specialist. Where appropriate, the consumer is transferred to the hospital for further investigation.

Requirement 3(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 that information about the consumer's condition, needs and preferences are documented and effectively communicated with those involved in the care of consumers. A review of care documentation, progress notes and care plans provide adequate information to support the effective and safe sharing of the consumer's information to support care. Consumers and/or representatives stated the consumers' care needs and preferences are effectively communicated between staff and the care they receive.

Registered nurses and care staff were able to describe how information is shared during the handover, through staff meetings and how changes are documented in progress notes and the handover sheet.

Requirement 3(3)(f) 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 timely and appropriate referrals to individuals, other organisations and providers of other care and services occur. Consumers and/or representatives stated that consumers have access to medical officers, physiotherapists, and other providers of care when needed. They said they had no problems with referrals to specialists or when a consumer needs to be transferred to the hospital.

Care plans include information about care management directed by the medical officer, physiotherapist, speech pathologist, wound specialist, palliative care specialist, dietician, podiatrist, dementia specialist and other health care providers. Registered nurses described processes for referring consumers to other health professionals and how the input of other health professionals informs care and services for the consumers. The information provided aligns with consumer feedback and care planning documents.

Requirement 3(3)(g) 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 there are processes in place to minimise infection related risks and to support the appropriate use of antibiotics to reduce the risk of increasing antibiotic resistance. The service clinical care manager is the service’s Infection Prevention and Control lead. The management team discussed, and the Assessment Team observed, appropriate infection prevention and control practices in relation to respiratory and other infections such as rapid antigen tests for all visitors and staff who enter the service and screening upon entry.

Clinical and care staff demonstrated sufficient knowledge of how infection related risks are minimised at the service. They provided examples such as environmental cleaning, hand hygiene, avoiding cross contamination, general infection control practices and the appropriate use of personal protective equipment where required.

Clinical staff explained the process of antimicrobial stewardship as it relates to their role. They described how they work with the care staff to prevent infections and work with the doctors for appropriate antibiotic prescribing. Other examples of strategies used to reduce infections were provided by staff, including encouraging fluid intake, cough etiquette, hand hygiene, appropriate hygiene, and overall cleanliness of the environment.

Consumers who have experienced infections provided positive feedback regarding the management of their infections. They stated they are satisfied with the service’s timely response to the symptoms, and review of care documentation confirmed that appropriate interventions were followed by the staff.

# Standard 5

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| Organisation’s service environment | |  |
| 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. | Compliant |

Findings

Requirement 5(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives expressed satisfaction with the service environment and their ability to move freely about the service, indoors and out. The Assessment Team observed the service environment to be safe, clean, and reasonably well-maintained. Maintenance schedules detail preventative and reactive maintenance, and there are cleaning schedules and communication books to ensure routine cleaning and cleaning by exception is completed.

Staff demonstrated an awareness of the processes involved when a hazard is identified or if equipment requires maintenance or repair. The Assessment Team observed cleaning staff performing scheduled and reactive cleaning tasks during the Assessment Contact.

# 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 |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Requirement 7(3)(a) 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 was able to demonstrate there are processes in place to ensure there are sufficient staff at the service. This was confirmed through interviews with consumers and/or representatives, review of documentation and observations. Staff indicated there are sufficient numbers of staff to meet consumer needs, and provided feedback stating staff are able to complete all their tasks during their shift.

Review of roster coverage and daily allocation lists for the last fortnight and discussions with the managers about rostering showed most rostered shifts are being filled. The service has a large casual pool which they can draw on to fill vacant shifts. Consumers and/or representatives indicated they felt there were sufficient staff and that staff attended to consumer care in a timely manner.

Requirement 7(3)(c) 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 was able to demonstrate there are processes established to ensure staff have the skills and knowledge to be competent at their job. The Assessment Team observed staff to be competent in their roles and consumers and/or representatives expressed satisfaction with care and services provided.

The training and development team described the training provided to ensure staff are skilled in their respective roles, including mandatory training, training during orientation as well as ongoing annual training. Competencies are role specific and include medication management, hand hygiene, personal protective equipment, and manual handling.

Consumers and/or representatives indicated they believe staff are competent in their roles and know what they are doing. Whilst the new staff do not know each consumer well, they are supported by the permanent staff in their day-to-day roles.

Training is based on observations completed by management, as well as feedback received from staff and consumers. A review of consumer surveys, incidents, complaints, and clinical data also identifies gaps in staff knowledge.

# Standard 8

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| Organisational governance | |  |
| 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. | Compliant |
| 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

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

The organisation’s governing body demonstrates that it promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery.

The service provides updates to senior management about risks, restraints, falls, weight loss, infections, high prevalence risk register and clinical risk indicators and pressure injuries. Management ensures the governing body is provided with all current information and is well informed and the governing body has oversight of what’s happening at the service level and can contribute to making improvements.

The governing body has allocated funding to have an inhouse multidisciplinary allied health team based at the service to provide strong clinical support for the care teams. The team includes a physiotherapist, speech therapist, occupational therapist, and an exercise physiologist. The organisation’s governance structure and framework was reviewed, and it identifies a leadership structure and who holds accountability for the quality and safety of care provided to consumers.

The organisation demonstrated effective organisation wide governance systems relating to continuous improvement, financial governance, workforce governance, and governance of feedback and complaints. However, the Assessment Team identified areas for improvement in relation to information management and regulatory compliance.

The service has a plan for continuous improvement that identifies opportunities for improvement through input from consumer feedback, complaints, audits, staff suggestions, review of clinical indicators, incidents, and outcomes of commission visits. Continuous improvement is discussed at governance meetings, leadership meetings and with consumers and staff at their meetings. In relation to organisational driven continuous improvement, the governing body has recently reinstated a person with clinical expertise in the organisation’s general manager residential services position providing an extra level of clinical oversight to all residential services.

The organisation has effective systems for financial governance and has a system of delegated authorities. The general manager residential services stated the operations manager has access to funds to purchase items and can make requests to the general manager residential services for out of budget expenditure when there is a need to support consumer care and service delivery.

The Assessment Team reviewed the recruitment process which includes strategies for workforce recruitment, retention, accountability, training, career pathways, and performance development. Along with a review of other documentation provided and discussions with the general manager residential services and operations manager, the Assessment Team found there is an awareness of local workforce challenges and actions have been taken to address this. The service has trained and upskilled all the permanent care staff to be medication competency trained, to allow the service more flexibility with their rostering and meeting consumer care needs.

There is governing body oversight of consumer feedback and complaints. This is evident in the reports provided to the governing body and information provided to the general manager residential services. They have a summary of feedback and complaint trends and actions are recommended to address adverse trends.

The organisation uses an electronic incident management system, but the service uses a paper-based documentation system to record all consumer care plan information. The residential managers and clinical care managers are manually developing reports for wound and pressure injuries, falls and other clinical data. Due to the paper-based system being used at the service, assessment and care planning documentation do not consistently provide adequate or consistent information about each consumers’ care needs, goals, and preferences.

Regulatory compliance obligations are generally reflected in organisational policy and procedure. The organisation has developed a terms of reference for their consumer advisory body meeting and communicated an expression of interest from for consumers to participate in the advisory body. Policy and procedure have been updated regarding approved provider governing body and key personnel obligations and about the aged care worker code of conduct. However, the Assessment Team identified areas for improvement in relation to behaviour support management, specifically related to behaviour support plans.

The Approved Provider responded with additional documentation and actions implemented to address the identified non-compliance, including but not limited to completing the transition to an electronic care system, and a review of identified consumers files.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(c) is found Compliant.

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 organisation demonstrated it has effective risk management systems and practices in place, including management of high-impact or high-prevalence risks, supporting consumers to live their best life, managing and preventing incidents, and identifying and responding to abuse and neglect of consumers.

Documentation review and discussion with the general manager confirmed that strategic risk has been a focus for the governing body and management. There are strategic risk registers for the various categories of risk, which are reviewed and updated, and there is internal and external support for the risk management function across the organisation, such as the quality, safety, and risk team. These are regularly reviewed and reported to the executive committees and the governing body.

There are organisational policies and procedures to guide staff practice in high-impact/high-prevalence risk management. The service has a high-impact/high-prevalence risk register for monitoring the top risks, and through the regular review of the register the service has identified skin integrity and falls as being high risk for consumers at the service. This has been escalated through to the operations manager and general manager residential services and raised at the quality safety committee for further review and discussion. As a result, there has been further education provided to staff in relation to these areas and further monitoring to evaluate the effectiveness of the training.

There are organisational policies and procedures about abuse and neglect of consumers and related reporting obligations, including in relation to the Serious Incident Response Scheme.

There are organisational policies and procedures to support consumer well-being. The organisation has processes for enabling consumers to take risks to live their best life and they have been effectively implemented at the service.

The organisation has an effective risk management system which directs the service’s incident and risk management processes. The organisation has policies and procedures to guide staff practice with incident management. Checks are undertaken on the service’s incident management system and areas for improvement are identified and actioned accordingly. Reports to the governing body show related data and information is reported on regularly and includes analysis, trending, and benchmarking results in relation to consumer incidents, complaints, and quality auditing.

Requirement 8(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 organisation has a comprehensive clinical governance framework in place which includes antimicrobial stewardship, minimising the use of restraint and open disclosure.

The organisation has policies and procedures to guide staff in antimicrobial stewardship. Most staff were familiar with concepts and practices to support appropriate anti-microbial use, and these were noted to be implemented at the service. There are organisational policies and procedures about minimising the use of restraint, and these seem to have been implemented effectively at the service. The organisation has several polices referring to open disclosure including the policy When Things Go Wrong. Staff could describe the process of open disclosure and were aware of open disclosure concepts and requirements.

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)