Performance

Report

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| Name of service: | HammondCare - Miranda |
| Service address: | 19 Kiama Street Miranda NSW 2228 |
| Commission ID: | 1006 |
| Approved provider: | HammondCare |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 November 2022 to 16 November 2022 |
| Performance report date: | 20 December 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 HammondCare - Miranda (**the service**) has been prepared by E Woodley, 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 7 December 2022.
* the Performance Report dated 4 April 2022 following the Site Audit undertaken from 22 February 2022 to 25 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 4** Services and supports for daily living | **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 | **Non-compliant** |

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) – Consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being. Restrictive practice processes are best practice, including used as a last resort after tailored non-pharmacological interventions to manage behaviour are evaluated as not effective, and interventions to manage behaviours are the least restrictive form possible. Consumer pain is appropriately assessed, managed and monitored to optimise their health and well-being.
* Requirement 3(3)(e) – Information about the consumer’s condition, needs and preferences is documented and communicated effectively to ensure it is understood by staff and others involved in the consumer’s care.
* Requirement 8(3)(e) – The clinical governance framework implemented at the service is effective in minimising the use of restrictive practices. This includes ensuring a consistent approach and understanding of individualised assessment, monitoring and management of restrictive practices.

# 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)(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. Three of the five specific requirements have been assessed and found Compliant.

The service was previously found Non-compliant in Requirement 2(3)(a), Requirement 2(3)(b), and Requirement 2(3)(e) following a Site Audit conducted 22 February 2022 to 25 February 2022. At the Assessment Contact conducted 15 November 2022 to 16 November 2022 the Assessment Team found the service has implemented actions in response to the non-compliance identified including:

* Review of consumer care plans to ensure accuracy, including review of behaviour support plans to ensure triggers and individualised strategies are identified.
* Implementation of a risk matrix to monitor risk and review of all current risk assessments.
* Review of palliative care and end of life care plans for consumers.
* Increased management oversight of incidents.

The Assessment Team found this has been effective in addressing the non-compliance in Requirement 2(3)(a) and Requirement 2(3)(b).

During the Assessment Contact conducted 15 November 2022 to 16 November 2022, the service demonstrated that assessment and planning includes consideration of risks to the consumer’s health and well-being and informs the delivery of safe and effective care. Consumers and representatives interviewed expressed satisfaction with the assessment and care planning processes and the care and services received. Consumer care documentation reviewed show consumers, and risks associated with their care, are assessed on entry to the service and a plan of care is developed to inform care. The service demonstrated assessment and planning identifies and addresses consumer’s needs and preferences including advance care planning and end of life care. Staff interviewed could describe what is important to the sampled consumers in terms of how their personal and clinical care is delivered, and this information aligned with what was in care documentation and feedback from consumers and representatives.

However, the Assessment Team found the service did not demonstrate appropriate review of care and services when circumstances change or when incidents impacted on the needs, goals and preferences of the consumer. For one consumer, assessments and interventions to manage risk of falls were not reviewed following falls incidents. For another consumer, pressure area care interventions documented in the care plan were inaccurate, and the Assessment Team found interventions to manage the consumer’s behaviours requiring support were not reviewed to ensure they are individualised and effective. One consumer experiencing behaviours requiring support did not have a behaviour support plan and while the consumer had been reviewed by specialist services, recommendations were not documented in care planning documentation.

The approved provider’s response included additional information about the care planning process being undertaken for the consumer at risk of falls, including falls prevention interventions implemented at the time of the Assessment Contact that are indicated to be effective. The approved provider’s response and Assessment Contact report did not indicate that behaviour management or pressure area care interventions documented were ineffective for the named consumer. The approved provider’s response includes additional information for the consumer who experiences behaviours requiring support, including that recommendations from the specialist services were received during the Assessment Contact.

Overall, the service and the approved provider’s response demonstrates that care and services are reviewed regularly for effectiveness, and when circumstances change or following incidents.

I find the following Requirements are Compliant:

* Requirement 2(3)(a)
* Requirement 2(3)(b)
* Requirement 2(3)(e)

# 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. | 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. | Non-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

The Quality Standard is assessed as Non-compliant as two of the seven specific requirements have been assessed as Non-compliant.

The service was previously found Non-compliant in Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(d), Requirement 3(3)(e) and Requirement 3(3)(g) following a Site Audit conducted 22 February 2022 to 25 February 2022. At the Assessment Contact conducted 15 November 2022 to 16 November 2022 the Assessment Team found the service has implemented actions in response to the non-compliance identified including:

* Staff education and training.
* Audits of consumer care plans, and reviews during clinical issues meetings.
* Improved monitoring and screening processes to ensure compliance with COVID-19 infection prevention and control precautions.
* Audits of personal protective equipment practices.
* Review of cleaning schedule and cleaning of equipment.
* Review of infections, and reporting of infections and antibiotic use to the medication advisory committee.

The Assessment Team found this has been effective in addressing the non-compliance in Requirement 3(3)(d) and Requirement 3(3)(g).

During the Assessment Contact conducted 15 November 2022 to 16 November 2022, the service demonstrated that deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. Clinical staff interviewed described how they review consumers in the event of suspected deterioration and provide required care such as checking observations, attending head to toe assessments, attending a delirium screen and referring to the medical officer or hospital if required. For a consumer sampled, deterioration in their mental health and a change in their bowels was identified and responded to appropriately.

The service demonstrated systems in place to minimise infection related risks through standard and transmission-based precautions. The service has implemented an antimicrobial stewardship policy with guidance for staff on best practice principles. Staff interviewed were able to describe the principles of antimicrobial stewardship and how they implement this in their daily work practices. The service demonstrated collection, trending and analysis of consumer’s antimicrobial usage data through their incident reporting system and discussions in regular quality risk meetings.

The service demonstrated the effective analysis of incident data captured in their incident management system. However, the Assessment Team identified for one consumer a behavioural incident was not reported by the staff per the organisation’s policy and gaps were identified in reviewing of the preventative strategies post-reoccurrence of a fall. For some consumers, the risks associated with the use of psychotropic medications were not included in their behaviour support plans.

For the consumer named in the Assessment Contact report, the approved provider’s response includes additional information about the fall prevention strategies implemented prior to the Assessment Contact, and the ongoing review processes during the Assessment Contact.

While gaps were noted in the documentation of consumer’s behaviour support plans and use of psychotropic medication, this has been considered in my assessment of Requirement 3(3)(a). Overall, I consider that the high impact or high prevalence risks associated with the care of consumer are effectively managed.

I find the following Requirements are Compliant:

* Requirement 3(3)(b)
* Requirement 3(3)(d)
* Requirement 3(3)(g)

However, the Assessment Team identified gaps in the clinical care for sampled consumers in relation to wound management, bowel care, restrictive practices, and pain management. The Assessment Team found gaps in wound assessment and documentation for one consumer. For one wound, assessment details did not include relevant information about the size and condition of the wound, and for another wound dressings were not attended per the directive and relevant information was not documented to monitor for healing or deterioration. For one consumer, the Assessment Team identified gaps in the escalation and response to bowel monitoring.

For the consumer named in the Assessment Contact report who had sustained wounds, the approved provider’s response demonstrates the wounds were assessed per the organisation’s procedures and incudes additional information about the dressings for one wound. The approved provider’s response demonstrates both wounds have healed, and overall wound assessment and management was effective. The approved provider’s response includes additional information about the bowel monitoring and management for the consumer named in the Assessment Contact report. This demonstrates, overall, the consumer’s bowels were monitored and managed appropriately, with no evidence of a negative impact on the consumer’s health and well-being.

For one consumer, the Assessment Team found the service did not demonstrate interventions to manage the consumer’s behaviours, or risks associated with other consumer’s behaviours, were reviewed to ensure they were the least restrictive form possible. For another consumer, the Assessment Team found gaps in the assessment and management of their pain. For example, the Assessment Team did not find evidence of review of pain following identified skin infection and increased agitation. The consumer’s pain was assessed once per day, with no timings recorded. There were indications of pain on most occasions with varying levels of effectiveness of the interventions implemented. While the consumer was commenced on a trial of a Schedule 8 pain patch following these indications of pain, the Assessment Team did not find evidence of regular pain review to monitor the effectiveness of this pain relief. This consumer’s behaviour support plan also did not include all relevant information about their behaviours, associated strategies to manage these behaviours, and risks associated with the use of restrictive practices. The Assessment Team found this consumer was administered chemical restrictive practice without evidence that non-pharmacological interventions to manage behaviours were implemented and evaluated as not effective prior to administration. For another consumer the Assessment Team found psychotropic medication was administered to manage the consumer’s behaviours, and this was not identified as a restrictive practice.

The approved provider’s response includes some additional information about the review and management of consumers subject to restrictive practices named in the Assessment Contact report. This includes the use of non-pharmacological interventions to manage behaviours in some instances, and clarification around the use of the medication for another consumer. However, I am not satisfied for all consumers named in the Assessment Contact report, non-pharmacological interventions to manage behaviours are implemented and evaluated as not effective prior to implementation of restrictive practice, and interventions to manage behaviours are the least restrictive form possible.

Overall, I am satisfied that the monitoring and management of consumer’s wounds and bowels are effective and optimising their health and well-being. However, I do not consider that restrictive practices, behaviour management, and pain management is consistently best practice, tailored to the consumer’s needs, and optimising their health and well-being.

The Assessment Team found information about consumer’s condition, preferences and needs was not always documented accurately and sufficiently, and communicated within the organisation, and with others where responsibility for care is shared. For one consumer, recommendations from an allied health professional regarding food and fluid intake were not included in the consumer’s care planning documentation. For another consumer, the Assessment Team found inconsistencies in the progress notes, care plan and diabetic care directive in relation to the management of their diabetes. For one consumer, the Assessment Team found gaps in the communication and understanding of interventions to manage risks associated with other consumer’s behaviours by the representative, staff, and in care documentation.

The approved provider’s response demonstrates that the management of the named consumer’s diabetes was in line with required directives.

The approved provider’s response includes additional information about the care planning process being undertaken for the consumer’s food and fluid intake recommendations, and this has since been updated on the consumer’s care planning documentation. While I acknowledge the consumer’s care plan was incomplete during the Assessment Contact, the service did not demonstrate effective processes to ensure recommendations from allied health professionals are consistently and accurately documented.

The approved provider’s response includes clarifying information about the risk management interventions for the consumer named in the Assessment Contact report, including the communication with the consumer representative. A dignity of risk form was signed following the Assessment Contact.

I am not satisfied the service demonstrated the documentation and/or communication of information about consumer’s needs and preferences were consistently effective for two consumers regarding their food and fluid intake needs, and needs and preferences regarding behavioural risk management interventions.

I find the following Requirements are Non-compliant:

* Requirement 3(3)(a)
* Requirement 3(3)(e)

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

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

The service was previously found Non-compliant in Requirement 4(3)(f) following a Site Audit conducted 22 February 2022 to 25 February 2022 as the service did not demonstrate consumer’s dietary requirements were consistently followed, and consumers were not provided choice or information about the meals served.

The Assessment Team found, in response to the non-compliance, the service conducted staff education and training. During the Assessment Contact conducted on 15 November 2022 to 16 November 2022, the service demonstrated consumers are provided choices of meals according to dietary requirements and assistance is generally provided in accordance with allied health recommendations. Overall, consumers and representatives interviewed by the Assessment Team provided positive feedback about the variety, quality and quantity of the meals provided at the service.

I find the following Requirement is Compliant:

Requirement 4(3)(f)

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

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

The service was previously found Non-compliant in Requirement 7(3)(a), Requirement 7(3)(c), Requirement 7(3)(d), and Requirement 7(3)(e) following a Site Audit conducted 22 February 2022 to 25 February 2022. At the Assessment Contact conducted 15 November 2022 to 16 November 2022 the Assessment Team found the service has implemented extensive actions in response to the non-compliance identified including:

* Recruitment and retention activities.
* Increased rostered hours for registered nurses and care staff.
* Staff training.
* Additional education and training positions.
* Review of the orientation and induction program.
* Monitoring of staff training and performance appraisals

The Assessment Team found this has been effective in addressing the non-compliance in Standard 7 identified at this Site Audit.

At the Assessment Contact conducted 15 November 2022 to 16 November 2022, consumer representatives interviewed by the Assessment Team said the staffing numbers deployed meets the care needs of consumers. Staff interviewed confirmed staff leave is normally replaced and they have time to complete their duties on their shift. Management demonstrated they monitor the care needs of consumers to determine the number and mix of staff to deliver the care required, and how they ensure the workforce is maintained to provide safe and quality care.

Consumer representatives interviewed by the Assessment Team were satisfied that staff are meeting the needs of consumers and were generally satisfied that staff are trained and competent to deliver the care and services consumers require. The service demonstrated a system for monitoring and ensuring staff complete their annual skills competency assessments. The service has improved the orientation process including additional buddy shifts, and providing training to ensure mentors are able to effectively train and support new staff. The organisation provides an ongoing training program for staff which includes annual mandatory training, online modules, additional training in response to identified needs, external training, face-to-face training and on the job training. The training program is monitored at a local and organisational level.

The Assessment Team found the organisation has developed a new tool to track the completion of annual performance appraisals which is monitored at an organisational level. A review of documentation demonstrated all staff working at the service during the Assessment Contact had a performance appraisal completed in line with the organisation’s policies, or had one booked for the following month. Management demonstrated staff performance is reviewed using consumer and staff feedback, investigation of incidents, review of clinical data, staff meetings, and observations by senior staff. Staff interviewed confirmed they had participated in an annual performance development meeting.

I find the following Requirements are Compliant:

* Requirement 7(3)(a)
* Requirement 7(3)(c)
* Requirement 7(3)(d)
* Requirement 7(3)(e)

# 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. | 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. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the five specific requirements has been assessed as Non-compliant.

The service was previously found Non-compliant in Requirement 8(3)(a), Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) following a Site Audit conducted 22 February 2022 to 25 February 2022.

At the Assessment Contact conducted 15 November 2022 to 16 November 2022 the Assessment Team found the service has implemented action in response to the non-compliance which has been effective in addressing the non-compliance in Requirement 8(3)(a). The Assessment Team found the service has reviewed the meeting structure and agenda to ensure consumers and stakeholders are encouraged and supported to provide input and feedback about the care and services provided. Consumers suggested focus groups be established for lifestyle and food. Management stated they will report back with the intention of commencing the focus groups in early 2023. Consumers and representatives interviewed confirmed they believe the service is well run and said they were able to make comments, suggestions and complaints.

The Assessment Team found the service and organisation had implemented continuous improvement in relation to organisational governance systems, risk management systems and practices, and clinical governance including:

* The development of a staff training plan, and completion of identified training.
* Review of the handover template.
* Additional education and training positions.
* Introduction of weekly clinical meetings, case reviews, audits and increased surveillance.
* Reporting on clinical indicators, incidents, key performance indicators, and complaints for monitoring by the organisation’s quality and management teams.
* The meeting structure has been reviewed and formalised with a schedule and agendas.
* The planned implementation of an electronic clinical documentation system.
* Review and upgrade of the risk management system to support more effective management, accountability and oversight of incidents.

At the Assessment Contact conducted 15 November 2022 to 16 November 2022, the service demonstrated effective organisational governance systems relating to continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. While the Assessment Team identified gaps in relation to consumer’s clinical care documentation and information, I have considered this in my assessment of Requirement 3(3)(a) and Requirement 3(3)(e). Overall, organisational governance systems were demonstrated to be effective.

The Assessment Team found the service has implemented a risk management system, including a framework, policies and procedures. A review of sampled incidents showed they were reported within the legislative timeframes and appropriate actions taken in response to the incidents. The service has a choice and decision-making policy which acknowledges dignity of risk and sets out how consumers’ choices are supported. Staff interviewed by the Assessment Team confirmed they had received training in relation to incident management and the serious incident response scheme. They could describe the steps they would take in response to an incident. While gaps were noted in the documentation of consumer’s behaviour support plans and use of psychotropic medication, this has been considered in my assessment of Requirement 3(3)(a). Overall, risk management systems and practices were effective in relation to the management of high impact and high prevalence risks, identifying and responding to the abuse and neglect of consumers, supporting consumers to live their best life, and managing and preventing incidents.

I find the following Requirements are Compliant:

* Requirement 8(3)(a)
* Requirement 8(3)(c)
* Requirement 8(3)(d)

The Assessment Team found the organisation has a documented clinical governance framework. At the local level clinical governance is overseen by the clinical care manager and reviewed at weekly meetings. There are reporting mechanisms and processes in place for the collection and reporting of data relating to clinical indicators, incidents, complaints, surveys and audits. This information is analysed, and actions are taken as necessary. A clinical governance advisor from the organisation provides oversight and support for the service. The Board has a subcommittee for clinical governance which reviews all clinical matters.

However, the Assessment Team found the organisation provided conflicting information about whether consumers are subject to environmental restrictive practice, as the service is a secure facility. Organisational consent forms identify consumers as subject to environmental restrictive practice, however this understanding was not reflected in service management’s response to the Assessment Team. The service did not demonstrate individualised behaviour support plans for the use of this restrictive practice, other than for those who exhibit exit seeking behaviour. However, one consumer with exit seeking behaviour did not have this information included in their behaviour support plan with individualised strategies to support this behaviour.

The approved provider’s response includes clarifying information and identifies that, overall, the organisation does not consider consumers are subject to environmental restrictive practice. However, the approved provider’s response acknowledges the service failed to follow the organisational procedures and correctly implement the appropriate documentation and consent for one consumer with exit seeking behaviour.

The service demonstrated effective clinical governance in relation to antimicrobial stewardship and open disclosure. However, the service did not demonstrate clinical governance was effective in relation to minimising the use of restrictive practice as there is conflicting information from the organisation, documentation, and service regarding the assessment of this. The service did not demonstrate individualised assessment was used to determine when the intervention (secure environment) is or is not an environmental restrictive practice.

I find the following Requirement Non-compliant:

* Requirement 8(3)(e)

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)