Performance

Report

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| Name: | Haydays Retirement Hostel |
| Commission ID: | 0212 |
| Address: | 256-260 Coke Street, HAY, New South Wales, 2711 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 13 March 2024 |
| Performance report date: | 10 April 2024 |
| Service included in this assessment: | Provider: 1089 Hay Senior Citizens Association Incorporated  Service: 228 Haydays Retirement Hostel |

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 Haydays Retirement Hostel (**the service**) has been prepared by Gai-Maree Cain, 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 9 April 2024, after an extension of 5 working days was granted at the request of the Approved Provider.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 8** Organisational governance | **Not 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)(b) – The approved provider must demonstrate consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being. Consumers’ skin integrity is appropriately assessed, managed and monitored to optimise their health and well-being. Restrictive practice processes are best practice, including used as a last resort, and with informed consent from the consumer and/or representative.
* Requirement 3(3)(d) – The approved provider must demonstrate effective systems to ensure the identification of deterioration or change of a consumer’s condition, and timely and appropriate response. This includes appropriate assessment/s and observations, and the consistent recording of this information.
* Requirement 8(3)(e) – The approved provider must demonstrate the clinical governance framework implemented at the service is effective in ensuring safe and quality clinical care to consumers. This includes minimising the use of restrictive practices, supporting consumers with changed behaviours, at risk of falls, in medication administration and wound care.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not Compliant |

Findings

The performance report dated 20 November 2023 found the service non-compliant in:

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

Deficiencies related to:

* The effective management of high impact or high prevalence risks in relation to falls, including the implementation of strategies to reduce risk of further injury or reoccurrence; for consumers’ experiencing pain is appropriately timed assessments and monitoring are not completed and unqualified staff are assessing pain and administering ‘as required’ medication; and risks associated with unplanned weight loss were not assessed and managed.
* The deterioration or changes in consumers’ mental, cognitive or physical function, capacity or condition not consistently being recognised and responded to in a timely manner in relation to diabetes and consumers who had experienced a fall.

***In relation to Requirement 3(3)(b)***

While consumers and representatives expressed satisfaction with all aspects of consumers’ personal and clinical care and the service had made some improvements the Assessment Contact Report contained information relating to deficiencies in the clinical care of consumers with changed behaviours, those subject to restrictive practices and post falls. Information included:

* Consumers at risk of falls were not consistently assessed or effectively managed, including the implementation of strategies to guide staff care delivery and minimise consumers’ risk of falling. Including one named consumer prescribed anti-coagulant medication and who had experienced 4 unwitnessed falls in less than 3 weeks. And while the service had implemented a high impact, high prevalence risk register, the register was not consistent with risk/s evidenced in consumers’ care documentation.
* For 2 named consumers who experienced pain, care documentation contained information that the assessment, monitoring and evaluation of pain is not consistently completed including be qualified staff; and as required medication was administered by care staff without the completion of appropriate pain assessment.
* Inconsistent understanding by staff of consumers who are or may be subject to restrictive practices including chemical and mechanical restrictive practices. Clinical staff at the service acknowledged the lack of training in relation to restrictive practices.
* Ineffective monitoring and management of risks associated with consumers who chose to smoke, and monitoring of consumers with known allergies.

The Approved Providers response submission accepted the findings as evidenced in the Assessment Contact report and provided evidence of completed and planned improvement actions as detailed in the plan for continuous improvement which was included in the response submission. Planned improvements included review and update of the Clinical Governance Framework with subsequent education to be scheduled for the Governing Body, Management Team, Registered and care staff; review of policies and procedures; education for staff on high impact, high prevalence risks; review of reassessment of all consumers, including those subject to restrictive practices to ensure appropriate assessment, consent and authorisation is in place. It is my decision, Requirement 3(3)(b) is Non-Compliant.

***In relation to Requirement 3 (3)(d)***

The Assessment Contact Report contained information that the service was unable to demonstrate that 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. Three named consumers were brought forward in the Assessment Contact Report:

* The first named consumer experienced changed pain and whilst this was identified by the service, adequate pain relief was not provided due to delays in dispensing prescribed medications by the pharmacy. Care documentation did not evidence monitoring of the consumers’ pain or a current wound, and as required medication was administered by care staff without the completion of appropriate pain assessment. The service was unable to demonstrate care staff who administer medication received appropriate training or had been assessed as competent for this task.
* Care documentation for a second name consumer identified episodes of changed behaviours, including refusing clinical and personal cares. However, the service had not responded to these changes in the consumer’s behaviour, care documentation was not contemporary and did not include individualised strategies to guide staff when the consumer presents with changed behaviour. The consumer is prescribed (and administered) a psychotropic medication, however, does not have a supporting diagnosis. This had not been identified by the service as a chemical restrictive practice.
* A third name consumer who is prescribed anticoagulant medication (which increases the risk of bleeding) had experienced 4 falls in the previous 2-week period, however, the service did not demonstrate consistent and timely assessment of the consumer after each fall. Care documentation did not evidence the identification of parameters for vital signs observations, or that care staff had been trained and assessed as competent in the assessment of vital signs including neurological observations.

The Approved Providers response submission accepted the findings as evidenced in the Assessment Contact report and provided evidence of completed and planned improvement actions as detailed in the plan for continuous improvement which was included in the response submission. One of the named consumers had been transferred to hospital after the Assessment Contact for review, and the service has successfully recruited additional Registered Nurses to undertake consumer clinical assessment and oversee clinical care. Planned improvements included review and update of clinical policies and procedures; implementation of deterioration trigger tools; education for staff in medication management and changed behaviours; and the development of a clinical assessment schedule. It is my decision, Requirement 3(3)(d) is Non-Compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not Compliant |

Findings

The performance report dated 20 November 2023 found the service non-compliant in Requirement 8 (3)(e), with deficiencies relating to the lack of a contemporary clinical governance framework which resulted in deficiencies in consumer clinical care delivery.

The Assessment Contact Report contained information that evidenced ongoing deficiencies in the clinical governance system and processes:

* Whilst the organisation had a documented clinical governance framework, including policies and procedures for, infection control management and antimicrobial stewardship, restrictive practices and open disclosure, these were not current. The service did not demonstrate an effective incident management system was in place, including the review and analysis of incidents to identify contributing factors, reassessment of consumers following incidents, and the implementation of preventative measures. The workforce at the service did not have the qualifications or knowledge to provide the oversight of consumers’ clinical care.
* Whilst staff had received recent education on clinical care, including minimising restrictive practices, implementing antimicrobial stewardship strategies, and open disclosure this had not been effectively implemented in the care and service delivery for consumers. For example, the service was unable to demonstrate the minimising of restrictive practices, including the appropriate assessment to identify if consumers were or may be subject to restrictive practices. Consumers care plans did not include comprehensive assessment and care planning to identify potential triggers for changed behaviours, or the implementation of appropriate strategies to support consumers.
* The service did not have a current Infection Prevention and Control Lead to oversee and monitor infection prevention and management practices at the service.
* The service did not evidence relevant training, education and competency assessment of staff who are providing direct clinical care to consumers’ (including when there is not an RN rostered on-site and on-duty at the service) such as administration of medications and undertaking clinical observations of consumers. This is further considered under my decision for Requirement 3(3)(b) and Requirement 3(3)(d).
* Deficiencies in consumer care documentation resulting in gaps in the identification, monitoring and managing of risk for individual consumers. I have considered this under my decision for Requirement 3(3)(b).
* Deficiencies in the clinical monitoring and management of consumers in relation to falls, pain, changed behaviours and wound management. I have considered this under Requirement 3(3)(d).
* Policies and procedures to guide staff to ensure quality and safe care were not contemporary.

The Approved Providers response submission accepted the findings as evidenced in the Assessment Contact report, and provided evidence of completed and planned improvement actions as detailed in the plan for continuous improvement which was included in the response submission. Planned improvements included review of the Organisational Governance and Clinical Governance Framework, incident management system and clinical care systems and process; and the development of a training matrix for all staff to include the education and competency assessment of workers who are providing direct clinical care to consumers’ (including when a registered nurse is not rostered onsite and on duty) and a mandatory training schedule. It is my decision, Requirement 8(3)(e) is Non-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)