Performance

Report

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| Name of service: | Hill View House - Merrimac |
| Service address: | 239 Gooding Drive MERRIMAC QLD 4226 |
| Commission ID: | 5503 |
| Approved provider: | Hill View Aged Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 January 2023 to 4 January 2023 |
| Performance report date: | 27 January 2023 |

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 Hill View House - Merrimac (**the service**) has been prepared by S Turner, 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 9 January 2023 accepting the Assessment Team’s recommendations
* the performance report dated 11 October 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 | 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 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 |

Findings

Following a Site Audit conducted 2 August to 4 August 2022, the performance report dated 11 October 2022, found Requirement 2(3)(a) to be non-compliant. Deficiencies related to the management of restrictive practice.

Consumers and representatives advised they are satisfied with the care consumers receive at the service. Representatives said they are consulted and involved in assessment and care planning processes, including in relation to changed behaviours. They described how the service effectively manages consumers with changed behaviours and that care and services provided met the consumers’ needs and minimised risk.

Staff were familiar with consumer’s identified care needs and could describe alternative strategies they use to minimise changed behaviours.

The organisation has policies and procedures to guide staff in their practice for completing consumer’s behavioural care documentation.

Behaviour assessment tools were used to assess consumers with changed behaviours and care documentation included individualised strategies to guide staff in assisting the consumer. The Assessment Team reviewed the care documentation for 11 consumers and found:

* assessments and authorisations for the use of restrictive practices were in place
* behaviour support plans were completed in consultation with representatives and reflected individualised strategies to minimise changed behaviours, and
* contemporaneous management of consumer behaviour, including evaluation and review processes had occurred.

The service has taken action to improve assessment and care planning processes, including in relation to changed behaviours and those consumers assessed as being subject to restrictive practices. Actions implemented included:

* The quality manager advised, and review of the Plan for Continuous Improvement confirmed, all consumer care documentation has been reviewed to ensure a behaviour support plan is in place where required; audits are undertaken to ensure these are reviewed. The Assessment Team confirmed current behaviour support plans are in place for consumers who exhibit changed behaviours.
* Management monitors consumer care documentation to identify incidents resulting from consumer behaviours and to ensure consumer care is reviewed to minimise risk.
* The care plan review process known as ‘resident of the day’ has been updated with reviews now being completed 3-monthly instead of every 4 months. The care manager has revised the ‘resident of the day’ tool to include review of consumer’s behaviour and behaviour support plan on a 3-monthly basis. Care plan reviews are allocated to registered nurses with oversight by the care manager to ensure completion. Staff meeting minutes demonstrated discussion regarding changes to this process and registered nurses were familiar with the changes.
* Education records demonstrated and staff confirmed, training has been provided in assessment and planning related to consumer’s behaviour management, the development of behaviour support plans and the engagement of representatives in this process. Behaviour support plans evidenced discussion with representatives.
* The service has updated the electronic care management system to include additional documentation fields to facilitate completion of behaviour support plans and consumers’ life story information. Registered staff advised, and meeting minutes confirmed, they have been provided with education relating to this.
* Restrictive practices are now a standing agenda item for the registered staff meeting and a review of meeting minutes confirmed this is occurring.
* Registered staff complete an annual medication competency which has been updated to include questions about clinical indications for psychotropic medications. The Assessment Team reviewed the revised medication competency and education records which demonstrated 100% of registered staff have completed the medication competency.

I am satisfied the service has taken action to improve assessment and care planning processes relating to changed behaviours and restrictive practices. Risks to the consumer’s health and well-being are being considered and this is informing the delivery of safe and effective care and services.

# 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 |

Findings

All consumers and representatives interviewed advised they are satisfied with the care consumers receive at the service. Consumers provided feedback including they ‘could not be happier with the care’ they receive.

Consumers’ care documentation demonstrated they are receiving safe and effective care including in relation to restrictive practices, pain management, wound care, changed behaviours and falls prevention and management. There was evidence of close monitoring of consumers by registered nurses, the involvement of allied health professionals and dementia advisory services, clinical equipment was available to support care delivery, and staff were familiar with non-pharmacological strategies to manage changed behaviours.

Management said they monitor the consumer’s condition, consult with consumers about their care, refer consumers to other healthcare providers when required, review care documentation and analyse incidents to identify any emerging concerns or care needs. The Assessment Team reviewed clinical indicator data, incident reports, care documentation and meeting minutes and confirmed management respond to any emerging concerns or changes in care needs for individual consumers.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

Following a Site Audit conducted 2 August to 4 August 2022, the performance report dated 11 October 2022 found Requirement 8(3)(c) to be non-compliant. Deficiencies involved the service’s governance systems relating to regulatory compliance.

The service has taken action to improve its performance in relation to this requirement. Actions taken included:

* Processes have been implemented to ensure all rostered staff have current police checks. The electronic rostering system has been upgraded and does not allow staff to be rostered if police checks are not current. The system prompts the human resource officer when staff police checks are due to expire in 3 months with ongoing prompts up to the date of expiry.
* Management meetings include a discussion of staff whose police checks are due for renewal and there is a process to ensure police check details are visible to management staff. The Assessment Team reviewed a report which demonstrated all staff police checks are current.
* Staff have received education and training in restrictive practices, dementia and behaviour support via meetings, toolbox sessions, individually and through self-directed learning. Staff confirmed they have completed training. The Assessment Team reviewed documentation which identified most staff have completed this training which is now included as part of the annual mandatory training requirements. Those staff who are outstanding are scheduled to complete this education in the near future.
* Restrictive practices and regulatory compliance are discussed at staff meetings and the organisation’s directors’ meeting.
* The restrictive practices’ policy and procedure have been updated to reflect current legislative requirements. The Assessment Team reviewed the documents which aligned with current legislative requirements.
* Additional staff members are receiving electronic mail alerts for regulatory changes which has led to improvements in communication to staff. The Assessment Team reviewed meeting minutes demonstrating discussions and actions taken in response to the changes associated with the Code of Conduct for Aged Care.

I am satisfied the service has effective governance processes including in relation to regulatory compliance.

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)