Performance

Report

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| Name of service: | Hillview Bunyip Aged Care Inc |
| Service address: | 22 A'Beckett Road BUNYIP VIC 3815 |
| Commission ID: | 3212 |
| Approved provider: | Hillview Bunyip Aged Care Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 11 August 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 Hillview Bunyip Aged Care Inc (**the service**) has been prepared by C Spiller, 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

# 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 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 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)(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

Requirements 2(3)(a), 2(3)(b), 2(3)(d) and 2(3)(e) were found non-compliant following a Site Audit from 1 March 2022 to 4 March 2022. The service did not demonstrate:

* a consistent approach to the assessment and planning including the risks to the consumer’s health and well-being informs the delivery of safe and effective services.
* effectively that assessment and care planning identified and addressed consumer’s current needs, goals and preferences including advanced care and end of life planning.
* that most care and services plans are complete and are available to consumers or representatives and other care providers as appropriate. The service’s policy regarding assessment and planning did not include information on sharing of consumer information and how to access care plans.
* incidents are always effectively managed, recorded, and actioned. The service did not adequately review the care and services for consumers who experienced a change in their care needs or circumstances. The care staff were unaware of the interventions and strategies documented in care plans to manage the care needs of consumers. Incident reports did not identify the cause of the incident and did not contain effective strategies to prevent reoccurrence or further deterioration.

In response to the non-compliance, the service implemented several initiatives as evidenced in the service’s plan for continuous improvement (PCI), which have been effective. Improvement actions included, but are not limited to the following:

* Employment of an admission nurse one day a week to complete and/or review assessments.
* Setting up the electronic care planning system to send clinical alerts to remind nursing staff to complete assessments according to the 30-day admission schedule.
* Including a discussion on advance care and end of life planning in the admission process. The detailed documentation is left up to the consumer or representative to complete and return to the service.
* Consumers and representatives receive newsletters that inform them about care plans and how the planning process works by involving them in the process.
* Consumers or representatives are encouraged by staff to retain or request a copy of the current care plan.
* Staff have received additional training in incident reporting, resulting in improved and streamlined process for clinical documentation.
* Clinical staff review and monitor changes in consumer needs and circumstances.
* Documentation of incidents is reviewed by the clinical manager.

During the Assessment Contact 11 July to 12 July 2023, in relation to Requirement 2(3)(a) the service demonstrated assessments and care plans identify consumer risk and are reviewed and monitored for safe and effective delivery of consumer care. All sampled consumers and representatives said they are happy with the care they receive. The representatives confirmed that they are notified of any incidents or changes to care needs. Staff described the process for conducting assessments including identifying risk. Policies and procedures, consumer file information, training records, and schedules provided by management confirm the initiatives implemented by the service. Documents reviewed by the Assessment Team reflect current assessments and information in the care plans in relation to behaviour management plans, and a mobility plan, following a change to their health status or an incident.

In relation to Requirement 2(3)(b) the service demonstrated assessment and care planning identifies and addresses the current consumer needs, goals, and preferences, including advanced care and end of life planning if the consumer wishes. Documents reviewed by the Assessment Team in relation to six consumer files show evidence of current consumer needs and preferences documented in care plans.

In relation to Requirement 2(3)(d) the service demonstrated that they are committed to improving the communication of care plan assessments and results. Sampled representatives said they participated in the care planning process and were contacted when circumstances changed for the consumer. They said they have been offered and/or received a copy of the care plan. Overall, consumer files reviewed show evidence of sharing the care plan with consumers or their representatives.

In relation to Requirement 2(3)(e) the service demonstrated care and services are reviewed and monitored for effectiveness and when changes occur that impact the needs of consumers. Nursing staff interviewed said they are more confident in completing incident reporting since receiving additional training. The clinical manager reviews incident reports and discusses with clinical staff strategies to avoid a reoccurrence of the incident or similar incidents. Interviewed consumer representatives' expressed satisfaction with the review process and the care and attention to detail when developing the care and services plan. Overall, consumers were pleased with the care assessment and planning and review processes and consider the staff respectful, helpful, and generous with their time when attending to their individual needs.

Accordingly, with the information available to me, the service is compliant with Requirements 2(3)(a), 2(3)(b), 2(3)(d) and 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. | 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 |

Findings

Requirements (3)(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) were found non-compliant following a Site Audit from 1 March 2022 to 4 March 2022. The service was unable to demonstrate:

* best practice and person-centred care in relation to skin integrity and wound management, management of pain, and restrictive practices.
* management of high-impact or high-prevalence risks in relation to consumer care relating to restrictive practices, nutrition and hydration, fluid restrictions, fluid charting and falls.
* timely identification of deterioration and response to pressure injuries experienced by a consumer who is now deceased.
* consistency in fluid charting, effective documentation when requesting a medical review for pain, and currency of handover sheets.

In response to the non-compliance, the service has since implemented several initiatives as evidenced in the service’s plan for continuous improvement, (PCI), which have been effective. Improvement actions have included, but were not limited to:

* reviewed and subsequently implemented a revised process for skin assessment and skin care management, reflective of best practice.
* reviewed the management of restrictive practices processes and practices. As a result of this review a revised process was introduced and aligns with best practice principles and meeting legislative requirements.
* provided education to staff around restrictive practice and processes.
* reviewed its pain assessment policy and process with the implementation of a revised process for assessment, monitoring, and review of pain reflective of best practice.
* reviewed and subsequently implemented a revised process for management of nutrition and hydration reflective of best practice and inclusive of consumers placed on fluid restrictions.
* reviewed clinical deterioration guidance and health changes process with documentation updated April 2023.

During the Assessment Contact on 11 July to 12 July 2023, in relation to Requirement 3(3)(a) the service demonstrated the provision of individualised personal and clinical care in relation to skin integrity and wound management, restrictive practices, and pain management. This care was shown to be aligned with best practice principles. All interviewed consumers and representatives said they were satisfied with the clinical and personal care consumers are receiving. Staff described personalised care that aligned with best practice, with documentation confirming consumers’ wounds, changed behaviour and restrictive practices, and pain are effectively managed.

In relation to Requirement 3(3)(b) the service demonstrated processes are in place to effectively manage high-impact or high-prevalence risks related to restrictive practices, nutrition, and hydration in relation to fluid restrictions, and falls. All interviewed consumers and representatives said they were satisfied care is effectively managed. Staff were able to demonstrate an understanding of the high-impact and high-prevalence risks associated with consumers. The service has policies and processes to guide staff in the management of high-impact and high-prevenance risks.

In relation to Requirement 3(3)(d) the service effectively demonstrated timely and appropriate identification and response to changes in consumers’ conditions when an incident occurred. All consumers and representatives said they are satisfied with responsiveness from service staff when there has been a change in consumer health status and staff are able to demonstrate how they identify and respond to consumers’ health deterioration. A review of documentation demonstrates staff identification and appropriate response to changes in a timely manner.

In relation to Requirement (3)(e) the service demonstrated effective communication of information about consumer conditions, needs and preferences. All consumers and representatives said they are satisfied with communication where responsibility for care is shared. Staff demonstrated how information relevant to consumer care is documented and communicated within the service. A document review evidences clear communication within the service about consumers’ condition, needs and preferences. The Assessment Team observed handover to be comprehensive and detailed with information relating to changes to consumers’ condition, needs, and preferences with handover sheets provided for further reference.

Accordingly, with the information available to me, the service is now compliant with Requirements (3)(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e).

# Standard 7

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| Human resources | |  |
| 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 service was found non-compliant with Requirement 7(3)(d) and 7(3)(e) during the Site Audit conducted from 1 March 2022 to 4 March 2022. The staff did not consistently demonstrate appropriate skills and knowledge relating to consumers’ care needs and requirements. It was identified that skin integrity, pain management, fluid intake, and restrictive practices were not effectively documented and managed at the service as per the established policies. The service did not demonstrate that staff requiring further training in assessment, planning, and the provision of clinical care were effectively identified through performance reviews and monitoring.

The service has implemented several actions in response to the non-compliance identified at the Site Audit in March 2022, which have been effective. Improvement actions have included:

* establishing an electronic training system as well as face-to-face training in collaboration with the clinical educator who joined the service in January 2023.
* education program addressing the knowledge deficits ongoing with a training plan.
* mentoring for inexperienced/new staff members with a minimum of 2 ‘buddy’ shifts, or until assessed as competent.
* quality audits identify areas for improvement and inform areas of education and training for staff.

During the Assessment Contact on 11 July 2023 to 12 July 2023, in relation to Requirement 7(3)(d) the service demonstrated they are committed to ongoing recruitment and building a resilient and skilled workforce. The organisation is reviewing and updating education and training focuses in-line with current legislation and where a learning need has been identified. The service has access to resources that support staff to deliver safe and effective care to consumers. Staff expressed positive feedback in relation to the support and provision of guidance and resources from management to enable positive outcomes for both learning and care and services delivery. Care staff demonstrated their understanding of pain assessment, skin assessment, and where to find behaviour support plans for consumers displaying changed behaviours.

In relation to Requirement 7(3)(e) the service demonstrated effective processes to assess, monitor and review the performance of the workforce. The service has position descriptions and duty lists related to staff roles, qualifications, and experience, with the expectations and applicable competencies identified. Performance review occurs for new staff at 3 months and 6 months post commencement, and annually thereafter. The service has policies and procedures in place relating to staff performance and disciplinary matters.

Accordingly, with the information available to me I find Requirement 7(3)(d) and 7(3)(e) as compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| 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

Requirements 8(3)(d) and 8(3)(e) were found to be non-compliant following a site audit conducted from 1 March 2022 to 4 March 2022.

The service did not have an effective process to monitor, analyse, and manage high-impact, high-prevalence risks associated with the care of each consumer. In particular, the service did not adequately demonstrate an effective clinical management framework for risks of pressure injuries, fluid intake, restrictive practices, and falls management for consumers in a consistent manner.

The service had a draft clinical governance framework that was not fully embedded into policies, processes, and staff practice. Management and staff were unable to demonstrate how they effectively monitor consumers’ prescribed psychotropic medications that are considered chemical restraint. The service had policies for minimising the use of restraint, however, management and staff were unable to demonstrate this was consistently applied.

The service has implemented several actions in response to the non-compliance identified during the March 2022 Site Audit which have been effective. The service’s clinical governance framework policy draft version dated 5 June 2023, describes the intention of establishing policies and work systems to drive behaviours, of both individuals and the organisation, to deliver quality, safe, and effective clinical and personal care for consumers. Clinical quality and safety are reviewed monthly by the leadership team to identify risk and monitor performance and improvements. The data is presented to the Board and strategic priorities are identified and used to inform planning and processes, as well as the national quality indicators that are reported to the Aged Care Quality and Safety Commission, consumers, representatives, and the workforce.

During the Assessment Contact on 11 July 2023 to 12 July 2023, in relation to Requirement (3)(d) the service demonstrated that they are implementing effective strategies to manage high-impact, high-prevalent risks. Policies and processes are reviewed with Board ratification and staff training in updated procedures is ongoing. Consumer assessments are performed by staff as scheduled and post changes to identify risks and strategies are implemented and evaluated as per policy. Staff described where to find policies and the mechanisms for escalating and reporting incidents. The service has a plan for continuous improvement (PCI) and actions are documented and instigated in relation to identified high-impact, high-prevalence risks.

In relation to Requirement 8(3)(e) the service demonstrated the clinical governance framework is underpinned and supported by the organisation’s corporate governance framework and the Board of management. This is evidenced by improved understanding and management of restrictive practices through the use of psychotropic medication assessment and diagnostic tools, reviewing and monitoring of the restrictive practice by the clinical management team, who are supported by medical practitioners and the organisations’ Board. Where a consumer was identified as experiencing a restrictive practice, either chemical, environmental, or mechanical, the Assessment Team saw documentation of informed consent and authorisation. Reviews of restrictive practice were occurring every 3 or 4 months in accordance with the service’s policy. Documentation review evidenced instances of minimising restraint and/or titration and cessation of medication where appropriate. Clinical staff described the organisations’ policy of comprehensive assessment processes and the need for informed consent and reviews in relation to restrictive practices.

Accordingly, with information available to me, the service is assessed as now compliant with Requirements 8(3)(d) and 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)