Performance

Report

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| Name of service: | Horton House |
| Service address: | 1A Ravenswood Avenue GORDON NSW 2072 |
| Commission ID: | 1037 |
| Approved provider: | Twilight House |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 May 2023 to 18 May 2023 |
| Performance report date: | 15 June 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 Horton House (**the service**) has been prepared by P. Sherin, 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 site audit report for the site audit conducted 14 December 2021 to 16 December 2021.
* other information and intelligence held by the Commission in relation to the service.

# 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 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 | **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 |

Findings

The service has taken action to address and remediate deficits leading to the non-compliance in the below Requirements as identified under the Site audit conducted 14-16 December 2021.

Requirement 2(3)(a)

The service demonstrated care planning documentation consistently captured effective risk assessment and planning to manage identified risks. Consumers and representatives confirmed consumers’ assessment and planning of care is effective and right for the consumer. Staff were able to describe how they ensure documented planning of care is consistent within consumers’ care and services plans. Management described how consumers are assessed for the use of various types of restrictive practice. Care documentation reflected the identification of risks to consumers, including consumers subject to a restrictive practice and a behaviour support plan in place.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate consistent care plan documentation from completed risk assessments in relation to food and fluid texture, management of constipation, and identification of consumers subject to restrictive practices. The service has implemented the following improvement actions to remediate these deficits:

* The organisation facilitated upgrades to the electronic care management system during March 2022 to ensure currency of risk assessment and planning forms, archiving of non-current documents, and enabling of automatic features to reduce the risk of manual errors. Review of consumer care planning documentation including nutrition and hydration care plans, bowel charts, and behaviour support plans identified consistency of information.
* Staff were provided training and information regarding changes to the electronic care management system and completion of consumer assessment and planning documentation. Interviews with staff and review of documents such as training records and meeting minutes confirms this.
* The service has employed a Quality manager and Dementia consultant who oversee and provide advice for individualised assessment and planning of consumers’ needs, including changes in consumer behaviours where a psychotropic medication has been administered.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 2(3)(b)

The service demonstrated assessment and planning addresses consumers’ needs, goals and preferences. Care planning documentation identified consumers with a diagnosis of dementia have individualised strategies to manage changes in their behaviours. Care and registered staff were able to describe activities and interests they facilitate as behaviour management strategies for specific consumers. Representatives of consumers subject to a restrictive practice said planned care for the consumer was individualised and ensured the consumer’s wellbeing.

The service was found to be non-compliant in the previous Site audit in relation to being unable to demonstrate oxygen management care plans and individualised behaviour management strategies for consumers that require this. The service has implemented the following improvement actions to remediate these deficits:

* An oxygen administration guideline and registered staff competency has been developed. Registered staff demonstrated knowledge of how to plan for management of oxygen and administration devices, and policies and guidelines to support planning of care for consumers prescribed oxygen.
* Daily progress note review commenced by the Clinical care coordinator and Quality manager to monitor and ensure staff are providing consumers with individualised behaviour management strategies prior to the administration of a psychotropic medication.
* All consumers with a diagnosis of dementia are reviewed regularly by the Dementia consultant, Clinical care coordinator and Quality manager to ensure individualised behaviour management strategies.
* Education to staff provided by the Dementia consultant on strategies to support consumers with a diagnosis of dementia to live the best life they can.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 2(3)(d)

The service demonstrated outcomes of consumers’ assessments and planning are discussed with consumers and representatives. The service implements a care plan schedule to ensure 4-monthly care plan reviews are completed by registered staff. Review of care planning documentation identified consumers and representatives are advised of changes in consumers’ care needs, and care plans have been reviewed and signed by the consumer and representative. Consumers and representatives confirmed they are involved in planning of consumer care.

The service was found to be non-compliant under the previous Site audit in relation to being unable to demonstrate care and service plans were effectively communicated to consumers and representatives. The service has implemented the following improvement actions to remediate these deficits:

* The Clinical care coordinator ensures consumer care plans and case conferences are scheduled with consumers and their representatives every 4 months.
* Completion of case conferences and care plan reviews are monitored and followed up with staff by the Clinical care coordinator. Outstanding care plan reviews are reported to the Quality manager and Facility manager via weekly meetings.
* The Clinical care coordinator and Quality manager monitor daily progress notes to ensure changes in consumer care needs are reviewed and to ensure consumer/representative involvement in planning of consumer care.

Based on the information recorded above, it is now my decision this Requirement is 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 |

Findings

The service demonstrated consumers are receiving safe and effective personal and clinical care. Consumers and representatives expressed satisfaction with the care consumers receive. Care planning documentation identified consumers who experience pain and constipation are monitored and appropriate strategies are implemented. For consumers subject to restrictive practices, an appropriate health professional authorisation, consent form, and behaviour support plan were in place.

The service was found to be non-compliant under the previous Site audit in relation to being unable to demonstrate safe and effective clinical care for the management of pain, constipation, oxygen administration, and restrictive practice. The service has implemented the following improvement actions to remediate these deficits:

* Consumers are reviewed for effectiveness of pain management strategies monthly and when there are changes in consumers’ pain. Consumer progress notes and pain charting are monitored to ensure effective pain management.
* A new process to monitor and manage consumers who experience constipation has been implemented. Consumers are monitored for constipation daily with the night duty registered nurse reviewing bowel charts for those consumers who have not opened their bowels for 3 days or more. A verbal handover is provided to the day registered nurse who further assesses the consumer for required interventions to promote bowel movement.
* The service has implemented oxygen management guidelines and staff competency. Refer to Requirement 2(3)(b) for additional information regarding management of oxygen therapy.
* Consumers are reviewed by the Clinical care coordinator, Quality manager and Dementia consultant on entry to the service for identification of a restrictive practice. Appropriate referrals for review by the medical officer, geriatrician and/or physiotherapist are made as required to ensure assessments and authorisations are in place.
* Consumers not subject to an environmental restrictive practice have been provided with an electronic fob to swipe the front door and exit the service as they choose.
* Daily progress note review commenced by the Clinical care coordinator and Quality manager to monitor and ensure behaviour management strategies are implemented by staff prior to the administration of a psychotropic medication; and ongoing review to ensure individualised behaviour management strategies are in place.
* Education to staff provided by the Dementia consultant on strategies to support consumers with a diagnosis of dementia to live the best life they can.

Based on the information recorded above, it is now my decision this Requirement is compliant.

# 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 service was found to be non-compliant under the previous Site audit in relation to not demonstrating effective measures to ensure the delivery of hot food to consumers eating within their rooms in response to reported dissatisfaction with the temperature of meals. Feedback from consumers and review of documentation such as complaints records and food focus meeting minutes identified consumers were satisfied with meals provided at the service, including meal temperature.

The service has implemented the following improvement actions to remediate identified deficits, which have been effective:

* Meal temperature checks are conducted to comply with food safety requirements and ensure that food served is at the correct temperature. Regular internal spot check audits are completed by the service’s Catering manager to monitor this. Review of meal temperature logbooks confirmed this occurs.
* Review of the service’s food delivery process resulting in the replacement of insulated food delivery trolleys with 3 new electric heated trolleys. The trolleys are heated before use and kept plugged in during meal service to ensure meals maintain their temperature. The assessment team observed electric heated trolleys in use during mealtimes.
* Consumer feedback is sought via random audits to gauge satisfaction with meal quality, quantity, and temperature. Review of audit records identified positive feedback.

Based on the information recorded above and positive feedback from consumers, it is now my decision this Requirement is compliant.

# 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 |

Findings

The service demonstrated an adequate workforce in place to ensure the provision of timely care and services catering to consumer needs. Consumers reported their personal and clinical care needs are attended to in a timely manner and in accordance with their preferences. Management described the processes in place to cover unplanned leave such as by utilising internal staff via shift bidding, sourcing staff from the organisation’s other services, or accessing agency staff. Management explained how ongoing recruitment, a supernumerary allocation of registered staff, and high level of staff retention are key contributory factors to the service providing a fully staffed workforce. Review of recent call bell records identified an average response time of 2 minutes and 45 seconds, with a maximum call wait time of 4 minutes.

The service was found to be non-compliant under the previous Site audit in relation to being unable to demonstrate its workforce was planned or resourced with adequate staff, contributing to delays and inconsistency in the provision of care and services to consumers in line with their preferences. The service has implemented the following improvement actions to remediate these deficits:

* The roster is monitored from the organisation’s corporate office using a traffic light system that identifies staffing requirements, the need for replacement shifts, and their urgency. Management confirmed the service has maintained full staff rosters including ensuring a registered nurse is available 24 hours a day.
* Internal workforce planning is reviewed each fortnight to identify staffing levels, the use of replacement staff, and emerging workforce needs.
* Call bells are monitored by the Clinical care coordinator, Facility manager and the executive management team. The service has set a call bell response time benchmark of less than 4 minutes. Any call bell response times that lay outside the service’s benchmark are investigated and escalated to management if excessive or recurrent. Any increases in call bell wait times that may be linked to staffing levels are escalated to the executive management team.

Based on the information recorded above and positive feedback received from consumers, it is now my decision this Requirement is compliant.

# 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

The service was found to be non-compliant under the previous Site audit in relation to being unable to demonstrate effective workforce governance, and regulatory compliance with restrictive practice requirements. The service has implemented the following improvement actions to address and remediate these deficits, as well as in relation to gaps in information management identified under the previous Site audit report:

In relation to workforce governance:

* The roster is monitored from the organisation’s corporate office using a traffic light system that identifies staffing requirements, the need for replacement shifts and their urgency. Management confirmed the service has maintained full staff rosters including ensuring a registered nurse is available 24 hours a day.
* Management advised a board sub-committee has been created to manage workforce issues. A labour force agreement has been approved to hire international staff and partnerships have been forged with registered training institutions to provide staff. The organisation’s human resources team are in the process of establishing a registered training agency that will educate and supply staff directly to the organisation’s services.
* Refer to Requirement 7(3)(a) for additional information.

In relation to regulatory compliance:

* Procedures for identifying and documenting restrictive practices have been improved at the service. Consumers are reviewed by the Clinical care coordinator, Quality manager and Dementia consultant on entry to the service for identification of a restrictive practice. Appropriate referrals for review by the medical officer, geriatrician and/or physiotherapist are made as required to ensure assessments and authorisations are in place.
* Consumers not subject to an environmental restrictive practice have been provided with an electronic fob to swipe the front door and exit the service as they choose.
* Refer to Requirement 3(3)(a) above for additional information.

In relation to information management:

* The organisation facilitated upgrades to the electronic care management system during March 2022 to ensure currency of risk assessment and planning forms, archiving of non-current documents, and enabling of automatic features to reduce the risk of manual errors.
* Management advised the executive management team regularly review the service’s plan for continuous improvement to ensure consistency of information and that all identified issues are classified correctly. Review of the service’s plan for continuous improvement confirmed it is kept up to date with each identified issue aligned with relevant Quality standards and requirements and outlining monitoring and completion dates.
* Refer to Requirement 2(3)(a) for additional information on consistency of care plan information.

Based on the information recorded above, it is now my decision this Requirement is 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)