Performance

Report

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| Name of service: | IRT Sarah Claydon |
| Service address: | 130 Princes Highway MILTON NSW 2538 |
| Commission ID: | 2706 |
| Approved provider: | Illawarra Retirement Trust |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 June 2023 to 20 June 2023 |
| Performance report date: | 1 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 IRT Sarah Claydon (**the service**) has been prepared by G Cherry, 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 10 July 2023 including a Plan for Continuous Improvement (PCI)
* Performance report dated 11 January 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 3** Personal care and clinical care | Non-compliant |
| **Standard 7** Human resources | Non-compliant |
| **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

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 1(3)(a) – implement an effective system to ensure each consumer is consistently treated with dignity, respect and their identity, culture and diversity valued
* Requirement 3(3)(b) – implement an effective management system of high impact/prevalence risks associated with each consumer’s care; in particular relating to post fall/pain and unmet behaviours
* Requirement 7(3)(a) – implement an effective system to ensure a planned and enabled workforce (and the number/mix of staff members) ensures delivery/management of safe quality care and services

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |

Findings

The Quality Standard was not fully assessed. One of six requirements was assessed and found non-compliant.

During this assessment contact information was gathered through interviews, observations. and document review. Sampled consumers/representatives gave mixed feedback; some consider consumers are respected, feel valued as an individual, are happy with care, staff are lovely and speak to them in a respectful manner, and know their individual preferences. Documentation relating to 2 consumers demonstrate their identity, culture and diversity needs are known by staff.

However, some consumers/representatives’ express dissatisfaction some staff interactions are disrespectful, plus a lack of timely response to requests for continence assistance negatively impact’s consumer dignity. One representative expressed dissatisfaction of doors to consumer’s individual rooms being locked preventing access, and several consumers/representatives express lack of cleanliness negatively impacts consumers sense of dignity and feeling of respect. The assessment team observed locked doors preventing consumer access to their rooms within the memory support unit (MSU), including locked external doors inhibiting access to outside areas without staff assistance in unlocking these. One representative advised dissatisfaction in relation to lack of podiatry care and another cited viewing their relative dressed in another consumer’s clothing – both issues result in a lack of dignity for their relative. One consumer’s behaviour of entering consumers rooms without invite is destressing for others. Management acknowledge awareness of cleaning and laundry concerns, advising ongoing communication with the cleaning organisation, plus a current order for flooring and furniture replacement.

In their response, the approved provider advised 2 locked doors to consumer’s rooms as a result of choice, obtaining a quote for auto release of external doors, provision of staff education/training in relation to aspects of this requirement, and offered surveys to consumers/representatives to gain level of satisfaction. In addition, contacted representatives to provide mementos/personal effects to assist in wayfinding, purchase of name plates for buildings and inclusion of cleaning staff in daily meetings to improve communication relating to required cleaning processes. They advised of planned engagement of a new podiatrist to assess all consumer’s needs, and planned implementation of a new clothes labelling/laundry process. Examples of processes to gather data/implement response actions in relation to consumer satisfaction is noted.

In consideration of compliance, while acknowledging immediate and planned actions documented within a PCI detailing responsibility and anticipated completion timeframes, I am swayed by the volume of dissatisfaction and concern the service’s self-monitoring systems did not identify deficits bought forward by the assessment team. I consider it will take some time for the approved provider to demonstrate sustainability of newly implemented processes, plus effectiveness of education/training to improve quality of care/service and demonstrate compliance.

I find requirement 1(3)(a) is non-compliant.

# 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. | Non-compliant |

Findings

The Quality Standard was not fully assessed. One of seven requirements was assessed and found non-compliant.

A decision was made on 11 January 2022 that the service was non-compliant in requirement 3(3)(b) after a site assessment conducted 14–16 December 2021.

Previously the service did not demonstrate effective management of high impact/prevalence risks associated with each consumers care. Some actions have been implemented since the assessment conducted 14-16 December 2021, which include:

* Implementation of a high-risk case management procedure for all consumers who are classified as high risk according to criteria
* Education for Registered Nurses (RNs) regarding wound care documentation and review of wound care by senior care manager to support appropriate/effective wound management
* In relation to post-falls management and falls prevention, staff required to complete education in relating to correct procedure/falls policy
* Psychotropic management and restrictive practice plan consent forms to be signed and uploaded in a timely manner, communicating with general practitioners (GPs), engaging medication management review consultants to complete medication audits and conduct education
* Care planning documentation emailed to next-of-kin (NOK) and GPs
* A review of behaviour support plans to ensure behaviour records are accurately capturing strategies, plus provision of education regarding behavioural management
* Staff education on documentation and monitoring of fluid balance
* Overview of the medication not administered process including staff education, weekly pharmacy reporting and night RN checking stock

During the assessment contact visit on 19-20 June 2023 information was gathered through interviews, observations, and document review. Management demonstrate improvement actions taken and explained processes to identify high impact/prevalence risks associated with consumer care including meeting forums of a multidisciplinary service level team and organisational senior clinical involvement to discuss individual risk and mitigation strategies. While organisational policies/procedures guide staff in relation to behaviour support, clinical risk, deterioration, falls and post-falls management, the assessment team note these did not consistently guide staff practice in successful outcomes relating to sampled consumers.

Interviewed consumers/representatives gave mixed feedback regarding satisfaction. Some express satisfaction relating to consumers care and review of documentation and management interviews demonstrate effective management of high impact/prevalence risks for some consumers.

However, via review of documentation the assessment team bought forward evidence of ineffective clinical monitoring for one consumer post fall and ineffective wound monitoring/pain management/clinical monitoring post fall for another. They note a lack of regular pain assessment/monitoring to ensure comfort for two consumer’s living with a pressure injury. One consumer advised of receiving irregular pain relief in relation to wound management. Review of one consumer’s documentation, staff interviews and observations by the assessment team note ineffective strategies/management of unmet behaviours due to possible difficulty in room identification. Interviewed staff advise of differing strategies however note each is ineffective and documentation did not contain effective interventions to guide care delivery/successful outcome.

In their response, the approved provider acknowledge deficits in recording of care provision (although contend care provision occurred), supplying documentation detailing immediate and planned actions, including review/communication with sampled consumers to ascertain positive outcomes, referral to external dementia support services for one consumer, staff education/training, implementation of new processes to elicit practice changes and continued support from organisational clinical staff until new management team is well established. In consideration of compliance, I acknowledge actions previously implemented result in demonstration of improved outcomes for some consumers, including data relating to wound management/healing. I acknowledge responses by the approved provider however am swayed by the evidence bought forward demonstrating a lack of effective management of risks associated with each consumers care, particularly relating to post fall/pain and unmet behaviours resulting in negative consumer outcomes. I consider it will take some time for the approved provider to demonstrate sustainability of newly implemented processes, plus effectiveness of education/training to improve quality of care/service and demonstrate compliance.

I find requirement 3(3)(b) is non-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. | Non-compliant |

Findings

The Quality Standard was not fully assessed. One of five requirements was assessed and found non-compliant.

During this assessment contact visit information was gathered through interviews, observations, and document review. Sampled consumers/representatives gave mixed feedback regarding satisfaction. Some express satisfaction relating to care, however some express discontent in extended wait times of staff response to requests for assistance, giving examples of attending the service to assist with meals due to lack of staff number to consistently meet consumers needs/preferences. Interviewed staff note they are generally able to provide consumer care however it can be delayed, plus lack of staff numbers in MSU when staff are required to attend other areas of the facility. The assessment team observed this to occur resulting in one staff within the MSU. Management advise use of agency staff and organisational recruitment processes to increase numbers of registered nurses and documentation demonstrate full coverage of staff rostering requirements.

In their response, the approved provider acknowledge challenges in embedding expectations and processes due to use of agency staff, citing commencement of week-day care meetings, reinforcement of support programs, further enhancements of agency orientation processes/ introduction of the Care Support Pack to assist with induction of agency staff, In addition, organisational initiatives such as Project Welcome (bulk recruitment of multiple staff) and ongoing recruitment processes assist in stabilising an internal workforce. It is noted increased processes relating to risks in utilising agency staff (due to recent staff turnover) was identified by the service. In consideration of compliance, I acknowledge immediate and planned actions however consider it will take some time to demonstrate sustainability of newly implemented processes, plus effectiveness of education/training to improve quality of care/service and demonstrate compliance.

I find requirement 7(3)(a) is non-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 |

Findings

The Quality Standard was not fully assessed. One of five requirements was assessed and found compliant.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate an enterprise-wide risk management framework is considered in the context of strategic priorities. The governing body determines organisational risk appetite and policies/procedures guide staff in expectations supporting risk management as does the organisational risk and assurance advisor. Strategic risk documentation relating to various risk categories are regularly reviewed/updated. Strategic risk is a focus of the governing body, Chief Executive Officer, and executive management team, including as it relates to consumer safety/quality of care. Quality assurance processes monitor compliance. Meeting forums are utilised to discuss/analyse/trend/benchmark results such as incidents, complaints, quality auditing and performance indicators. Reports detail related improvement activities implemented due to self-identification of issues and/or analysis of data to ensure improved consumer outcomes. The service demonstrate immediate responsive actions (including adhering to legislative reporting responsibilities) in relation to recent incidents of inappropriate staff behaviour towards consumers.

I find requirement 8(3)(d) is compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)