Performance

Report

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| Name: | IRT St Georges Basin |
| Commission ID: | 0343 |
| Address: | 87 Loralyn Avenue, ST GEORGES BASIN, New South Wales, 2540 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 1 May 2024 to 2 May 2024 |
| Performance report date: | 12 June 2024 |
| Service included in this assessment: | Provider: 835 Illawarra Retirement Trust  Service: 359 IRT St Georges Basin |

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 St Georges Basin (**the service**) has been prepared by Therese Solomon, 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 22 May 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed. |
| **Standard 6** Feedback and complaints | **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 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

Requirement 3(3)(a) was found non-compliant at a previous assessment, where it was identified that consumers and/or representatives had concerns about the safety and effectiveness of care and services provided to consumers, specifically related to changing behaviours, falls, restrictive practices, pain, wounds, and medication management. The service implemented actions to address the non-compliance including implementation of a new medication management process, and education provided to staff on continence management.

During this assessment contact, consumers and/or representatives reported satisfaction with care and services provided to consumers, and stated consumers get the care they need, and that care is in line with their preferences. Staff described the care needs of consumers and strategies they use to support and manage consumer needs.

Clinical documentation showed the service has been managing changing behaviours effectively while also reducing the use of chemical restraint medications. Documentation confirmed consultation occurring between the service, the medical officer and the consumer representatives when reviewing medication usage and the ongoing need for the medication. Behaviour charts confirmed minimal behavioural challenges occurring since ceasing the medication, and management confirmed staff are engaging consumers in activities to reduce the frequency of incidents.

The service has strategies in place for individual consumers to reduce the number of falls and reduce injury. Clinical staff confirmed interventions utilised for consumers who are high falls risks, such as frequent sight checks and ensuring appropriate footwear is worn. Falls are discussed at handover and through staff messaging in the clinical documentation system.

Consumers and/or representatives advised they consider consumer’s pain is managed effectively by the service. The organisation has a pain management procedure which directs all staff to report to the registered nurse or team leader when a consumer voices or exhibits signs of pain. For some consumers pain is being identified and managed, however for some consumers who are unable to articulate their pain, inconsistent documentation in pain charting was noted.

A review of documentation for consumers with diabetes or concerns related to their blood glucose levels showed consumers have a diabetic management plan in place. However, not all plans were being followed per directive, to ensure consumer safety regarding diabetic management of blood glucose levels. The management team indicated the electronic medication management system does not interact with their electronic care management system, resulting in alerts not being raised if a consumer’s blood glucose levels are out of range ensuring staff follow up.

The Assessment Team identified areas for improvement related to wound care documentation, pain documentation and blood glucose level documentation.

The Approved Provider responded with additional information and a plan for continuous improvement containing actions to address the non-compliance, including ongoing education and reminders for staff on blood glucose level monitoring, and conducting weekly audits on staff practices related to blood glucose level monitoring. The Approved Provider’s response submission acknowledged some of the findings contained within the Assessment Contact report, however further clarifying information was provided demonstrating compliance with the Requirement.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including further education and observation of staff practices and have taken immediate action in response to areas of the Assessment Contact report including adding additional steps when capturing blood glucose levels in their documentation system to reduce risks to consumers. This Requirement requires that each consumer gets safe and effective personal care and clinical care that is best practice, tailored to consumer needs and optimises consumer health and well-being.

Therefore, it is my decision that Requirement 3(3)(a) is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement 6(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

During the previous assessment contact it was identified that documentation did not consistently show that appropriate action is taken in response to complaints. Evaluation of the effectiveness of actions taken to resolve complaints was not demonstrated in documentation or during interviews with management. Staff had documented some complaints made by consumers related to serious incidents but did not escalate them to ensure appropriate action is taken in a timely manner. The service implemented actions to address the non-compliance including that all feedback and complaints process to be actioned by local managers as per organisational policy, that the complaints process to be a standard agenda item at resident meetings, and for the management team to review current feedback and complaints register.

During this assessment contact it was identified that the feedback and complaints policy incorporates an open disclosure process, and registered nurses and care staff described how they apply open disclosure to their care of consumers and how it is used when consumers raise concerns about their care and services. Staff confirmed they had received education by the service about open disclosure.

Consumers and/or representatives stated that appropriate actions are taken in response to complaints. Staff indicated that they would try and assist consumers with their complaints and would escalate the issue to registered nurses or management if they could not resolve it for the consumer. The service’s complaints register details the complaint, actions taken, the resolution, and timeframe taken to resolve the complaint. Most complaints on the register had been resolved and closed in a timely manner.

# 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

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

During the previous assessment contact it was identified that consumers and/or representatives felt more staff training was needed in areas such as cleaning. Training records showed some training and competency assessments were not well attended in areas such as fire safety and code of conduct. Areas of care and services were found to have significant deficits despite related training being well attended. The service implemented actions to address the non-compliance including the development of a compliance education plan, development of an agency orientation folder, and scheduling fire training for staff.

During this assessment contact the service demonstrated that its workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. Consumers and/or representatives reported they felt that staff are well trained and know their needs and did not identify any areas where they felt staff needed additional training.

Clinical staff confirmed they had received training in restrictive practices, Serious Incident Response Scheme, infection control, and incident management requirements through the electronic learning system and face-to-face training sessions. New staff are buddied with an experienced staff member and work through a competency checklist. The Assessment Team observed a new staff member completing a buddy shift and were shown the checklist they were working through. The new staff member reported they were required to attend training before they could start providing care, and the topics included infection control, manual handling, dementia, fire safety, and code of conduct.

The service has introduced a 5-hour training programme which all staff must complete each year, topics include, clinical deterioration, medication and pain, falls prevention and post falls management, wound care, and code of conduct. Management stated the service has employed another educator who commenced in December 2023, and that they are based onsite fulltime to assist the current educator who oversees training across multiple sites.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

During the previous assessment contact it was identified that regular performance review for all staff had not occurred and there was a lack of effective oversight of performance review completions. The service implemented actions to address the non-compliance including support from the human resource team onsite to assist staff with completing their self-assessment, observations of staff practices completed by the service manager, education referrals to address identified deficits in staff performance, and identify all outstanding staff performance reviews and delegate them for completion by relevant managers.

During this assessment contact the service demonstrated regular monitoring and review of the performance of each member of the workforce. The organisation has a policy related to staff performance management, and includes processes for regular assessment, monitoring, and review of staff performance.

The service demonstrated staff performance is regularly assessed, monitored, and reviewed. Documentation reviewed showed there are no staff overdue for a performance review. Staff stated they had performance appraisals completed, and confirmed the process was supportive. Staff gave examples of being supported to attend external training development as a result of their performance appraisal.

Management advised that feedback about staff performance is captured in different ways, including through audits, consumer and/or representative feedback, staff feedback and observations. Management explained the services’ disciplinary process and stated policies and procedures are available to guide management through performance management processes when required.

# 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 |
| 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

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

During the previous assessment contact the Assessment Team identified deficiencies in relation to the service’s effective implementation of organisational policies and procedures. The service implemented actions to address the non-compliance including the development of a compliance education plan which includes mandatory training in medication competency, incident identification and code of conduct training, increased communication with staff at daily huddles and the monitoring of workforce management systems and processes to ensure they are implemented effectively.

During this assessment contact staff confirmed they can easily access information they need to effectively perform their roles. Policies and procedures developed by the organisation facilitate the collection and storage of information which is used to deliver effective care and services. Interview with the executive general manager, residential services, service management and review of documentation shows there are systems and processes to support information management, and this is regularly reviewed for effectiveness.

The organisation has a continuous improvement system which includes audits, feedback and observations which are fed into their continuous improvement plan. Interview with the executive general manager, residential services, service management and review of documentation shows the systems and processes in use are identifying areas for improvement. The executives and governing body show support for improvements to be made.

Interviews with the management and the executive general manager residential services, indicate there are operating budgets, capital expenditure budgets and processes for funds to be sought outside of budget when needed; as well as delegations of authority for spending funds and approving financial commitments. Documentation supports evidence the governing body has visibility and oversight of the organisation’s finances.

Workforce continues to be recognised as a high-risk area in strategic and operational planning. The organisation is continuing to utilise an overseas staff recruitment program and attracting and retaining workers by providing traineeships and accommodation onsite. The Assessment Team noted 4 additional staff members have recently commenced employment at the service, and agency staff are used to supplement staffing levels. The executive general manager residential services said the agency staff are blocked booked so they can learn the service’s processes and become familiar with consumers. The executive general manager residential services stated the organisation is providing financial incentives to attract registered nurses with some success noted. Overall, strategies and planning by the organisation are ensuring there is enough skilled and qualified members of the workforce to deliver safe quality care and services.

Regulatory compliance obligations are reflected in organisational policy and procedure. Policy and procedure have been updated regarding approved provider governing body and key personnel obligations. The board consists of majority non-executive members with 2 members of the board having clinical experience. The organisation has already had a quality care advisory body in place for some time and have recently held their first consumer advisory body meeting with a consumer and a representative from the service attending.

The organisation has a feedback and complaints management system in place and uses consumer input and feedback to inform continuous improvement at the service. The governing body has oversight of consumer feedback and complaints, and this is evident in the care governance committee meeting minutes, provided to the executive general manager, residential services, and the board. They have a summary of feedback and complaint trends and actions are recommended to address adverse trends.

Requirement 8(3)(d) was found con-compliant at a previous assessment, where deficiencies were identified in relation to staff practices, specifically in relation to identifying and escalating incidents in a timely manner increasing the risks associated with the care of consumers. The service implemented actions to address the non-compliance including staff training in incident identification and escalation, provide staff with an Incident Management Framework Guide and its application as it relates to their role, and the introduction of a new medication management system and improved medication management.

During this assessment contact the Assessment Team found the organisation has an enterprise-wide risk management framework and a risk appetite statement, clarifying the organisations boundaries of risk tolerance across the organisation and as it relates to care and services for consumers. There are organisational policies and procedures to guide staff practice in high-impact or high-prevalence risk management, identifying and responding to abuse and neglect of consumers and managing and preventing incidents, including the use of an incident management system. The service has developed a high impact high prevalence risk register for monitoring risks.

Information provided to the Assessment Team demonstrated that an investigation process occurs showing how the service completes an assessment on what can be done to reduce the risk of recurrence and support safer care. Review of documentation shows information about the abuse and neglect of consumers is reported to the governing body; however, the organisation has identified though the last Commission’s visit and their own internal audits that some staff are not identifying incidents and therefore not reporting the incidents as they occur. This information prompted a roll out of mandatory training across the service on incident management and Serious Incident Response Scheme reporting requirements. The executive general manager residential services, and the management team indicated they continue to closely monitor incident reporting at the service and regularly discuss the importance of accurate reporting at daily huddles and staff meetings.

There are organisational policies and procedures to support consumer well-being. The organisation has processes for enabling consumers to take risks to live their best life and they have been effectively implemented at the service.

The Approved Provider responded with additional information and a plan for continuous improvement containing actions to address the non-compliance, including ongoing education and training for staff. The Approved Provider’s response submission acknowledged some of the findings contained within the Assessment Contact report, however further clarifying information was provided demonstrating compliance with the Requirement.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including further education and observation of staff practices and have taken immediate action in response to certain areas of the Assessment Contact report. This Requirement requires that the organisation has effective risk management systems and practices in place.

Therefore, it is my decision that 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)