Performance

Report

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| Name of service: | Japara Balmoral Grove |
| Service address: | 24-34 Smith Street GROVEDALE VIC 3216 |
| Commission ID: | 3540 |
| Approved provider: | Calvary Aged Care Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 December 2022 to 7 December 2022 |
| Performance report date: | 16 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 Japara Balmoral Grove (**the service**) has been prepared by S Byers, 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 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 5** Organisation’s service environment | **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 2

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| Ongoing assessment and planning with consumers | |  |
| 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)(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

The service was found non-compliant in Standard 2 in relation to Requirements 2(3)(b) and 2(3)(e) following a site audit in August 2021 where it was unable to demonstrate:

* the consumers’ current needs, goals, and risks were identified, addressed and documented in assessment and care planning documentation
* care and services were reviewed for effectiveness when circumstances change or incidents impact on the needs, goals and preferences of the consumer.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives provided positive feedback in relation to the service’s management of falls and skin integrity. Care planning documentation detailed the consumers current needs, goals and preferences, including specific risks to their health and well-being. Care planning and assessment documentation including risk assessments reflected the current mobility status and clinical condition for consumers who experienced falls, including upon return from hospital. Consumer documentation was consistent with handover sheets and high risk alerts in the electronic management system. All consumer files reviewed included advance care directives. Staff understanding of consumer needs and preferences aligned with information provided by consumers and documentation.

Representatives said they are updated about any incidents that occur. Representatives confirmed consumers are reviewed by their medical officer and allied health professionals after incidents and changes to health status. Consumer files demonstrated assessments and care plans are updated in a timely manner when circumstances change and after incidents. Clinical staff described the care plan review process that involves collaboration with consumers and representatives. The service has implemented a care planning review process to monitor and ensure care plans are reviewed and updated every three months or when circumstances change. Incidents are reviewed monthly as part of a newly established quality review process. Registered nurses have been trained and supported to review incidents in the electronic management system. Education has been delivered to staff in relation to assessment, care planning and review.

Based on the available evidence, I am satisfied the service has in place effective assessment and planning systems to ensure the consumers current needs, goals and preferences including advanced care planning are identified and addressed, and 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. I find Requirements 2(3)(b) and 2(3)(e) are 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The service was found non-compliant in Standard 3 in relation to Requirements 3(3)(a) and 3(3)(b) following a site audit in August 2021 where it was unable to demonstrate:

* care and services were provided using best practice principles in a timely manner for skin integrity and restrictive practices
* effective management of high impact or high prevalence risk in relation to falls, pressure injuries and choking.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service demonstrated best practice personal and clinical care are provided according to the consumers individual assessed needs in relation to skin integrity and restrictive practices. Representatives were satisfied with the personal and clinical care provided to the consumer and communication received from the service. Staff demonstrated understanding of the process for safe and effective use of restrictive practices. Behaviour support plans are in place for all consumers who exhibit responsive behaviours and those consumers who are subject to chemical restraint. Behaviour support plans and psychotropic medications are reviewed regularly and informed consent obtained. Staff described the effective non-pharmacological strategies used to support consumers that aligned with the consumers care documentation. Staff feedback and consumer file review demonstrated timely identification, assessment and management of skin integrity issues. Staff described having access to a wound consultant for complex and chronic wounds. Staff have completed training in care documentation, effective skin integrity care and pressure area prevention and management.

Consumers expressed satisfaction that risks are management effectively. Clinical staff described the processes in place to effectively manage high impact and high prevalence risks relating to falls, pressure injuries and choking, including escalation procedures and consultation with consumers and representatives. Consumer file review demonstrated that risks associated with choking, falls and pressure injuries are managed in accordance with the services policies and timely referrals are made to medical officers and allied health professionals for review. For example, physiotherapist post falls and speech therapist post choking episode. Assessment and care planning documents were updated to reflect new personalised recommendations and strategies in relation to risks associated with the care of each consumer.

Based on the available evidence, I am satisfied the service has in place effective systems to ensure each consumer gets care that is best practice, tailored to their needs and optimises their well-being and effective management of high impact and high prevalence risks associated with the care of each consumer. I find Requirements 3(3)(a) and 3(3)(b) are 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 was found non-compliant in Standard 7 in relation to Requirement 7(3)(a) following a site audit in August 2021 where it was unable to demonstrate:

* the numbers and mix of the workforce deployed sufficiently enabled the delivery of safe and quality care and services.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

While consumers and representatives were aware of staff shortages, they provided positive feedback in relation to the care provided and reported that staff respond to requests for assistance promptly. Staff provided feedback that there are shortages in kitchen and care staff, however identified the shortages do not impact the delivery of care and services to consumers. Roster documentation demonstrated that an appropriate mix of skill and roles are planned and allocated throughout the service. While roster documentation showed unfilled shifts for the week prior to the site audit, management were aware of the shortages, identifying unplanned leave as an ongoing area of improvement and described the strategies in place to manage the unplanned leave to limit impact to care delivery. Staffing continues to be an action on the services plan for continuous improvement with ongoing recruitment to fill vacancies. Staff confirmed the recruitment of several new staff including two clinical care managers and nursing staff. Overall, call bell reports indicated call bells are responded to in a timely manner and extended response times are reviewed by management.

Based on the available evidence, I am satisfied the service has in place systems and processes to ensure 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. I find Requirement 7(3)(a) is 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

The service was found non-compliant in Standard 8 in relation to Requirements 8(3)(d) and 8(3)(e) following a site audit in August 2021 where it was unable to demonstrate:

* effective risk management systems in relation to identifying and managing high impact and high prevalence risks and incident management
* a clinical governance framework that effectively managed and minimised restraint.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The organisation demonstrated effective risk management systems and practices are in place in relation to high impact or high prevalence risks and incident management. A quality board and falls committee has been established to ensure ongoing oversight to risk management and monitoring, particularly to address high fall risks. A new electronic management system has been implemented to record incidents. Staff training has been delivered in relation to recording incidents in the new system and SIRS obligations. Staff demonstrated understanding of incident reporting obligations and processes. Documentation including incident forms and incident register demonstrated incidents are appropriately recorded, reported and analysed for trends.

The organisation demonstrated effective clinical governance systems and processes are in place to guide staff practice in relation to minimising the use of restraint. The organisation has implemented a new electronic management system to accurately record and manage psychotropic medications. Education has been delivered to clinical staff to improve monitoring of psychotropic medications and chemical restraint. The organisation has implemented an ongoing review of consumers medication to reduce the use of chemical restraint. Care and clinical staff demonstrated an understanding of the use of chemical restraint, informed consent and trialling non-pharmacological strategies prior to use of chemical restraint.

Based on the available evidence, I am satisfied the service has in place effective risk and incident management systems and a clinical governance framework that minimises the use of restraint. I find Requirements 8(3)(d) and 8(3)(e) are 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)