Performance

Report

**1800 951 822**

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| Name of service: | Jewish Care (Vic) Inc. Residential Homes, Windsor |
| Service address: | 619 St Kilda Road MELBOURNE VIC 3004 |
| Commission ID: | 3024 |
| Approved provider: | Jewish Care (Victoria) Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 April 2023 to 14 April 2023 |
| Performance report date: | 19 May 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 Jewish Care (Vic) Inc. Residential Homes, Windsor (**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
* the provider’s response to the assessment team’s report received 4 May 2023

# 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 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 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. | Compliant |

Findings

The service was found Non-compliant in Standard 1 in relation to Requirement 1(3)(a) following a site audit in July 2022 where it was unable to demonstrate:

* Each consumer is treated with dignity and respect, specifically in relation to hygiene care.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives said they are treated with dignity and respect and feel their identity, culture and diversity is valued. The service has implemented changes to the handover process to include consumer hygiene preferences and developed improved work instructions to support staff practice. Staff have completed training in the new handover process, reporting requirements and hygiene and personal care. Staff demonstrated their understanding of each consumers identities and provided examples of how they treat consumers with dignity and respect, including when delivering hygiene and personal care. Consumer care documents were individualised and reflected the background, culture, and preferences of each consumer. The Assessment Team observed staff interactions with consumers to be respectful, and all consumers to be neat and well-presented.

Based on the available evidence, I find Requirement 1(3)(a) is Compliant.

# 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 |

Findings

The service was found Non-compliant in Standard 2 in relation to Requirement 2(3)(a) following a site audit in July 2022 where it was unable to demonstrate:

* Assessment and care planning considered risks associated with pain, risks and effective strategies were accurately recorded in care plans, and pain charting and assessments were completed in line with the services work instructions.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives expressed confidence that the assessment and care planning process considers the risks to the consumer’s health and well-being in relation to pain. The service demonstrated it has policies and procedures in place to guide staff in assessment, care planning and risk management. Clinical and care staff demonstrated knowledge of individual consumer risks and described relevant strategies to ensure the delivery of safe and effective care. Care documentation reflected risks associated with pain are assessed, completed risk assessments are recorded, strategies are documented, and care plans are developed in consultation with the consumer and their representative. Pain charting was in place and pain assessed in accordance with organisation policy. Staff have received training in risk assessments and care planning.

Based on the available evidence, I find Requirement 2(3)(a) 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found Non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b) and 3(3)(g) following a site audit in July 2022 where it was unable to demonstrate:

* Each consumer received best practice personal and clinical care in relation to restrictive practices and pain management.
* Effective management of high impact or high prevalence risks, associated with pain and wound management.
* Effective standard and transmission based precautions to prevent and control infection.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives were satisfied with how the consumer’s pain was managed by the service. Care planning documents detailed ongoing assessment, monitoring and evaluation of care in collaboration with specialist services. Staff demonstrated a sound knowledge of consumer’s non-pharmacological pain management strategies that aligned with the consumers assessed care needs. Consumers subject to restrictive practices had personalised behaviour support plans in place, with evidence of informed consent and ongoing medical review. The service demonstrated it had reviewed its clinical processes and delivered training to staff in relation to restrictive practices, and pain assessment and monitoring.

The service demonstrated it engaged a wound consultant to review all wounds at the service and provide recommendations. Review of consumer documentation demonstrated all recommendations were being followed in practice. The service demonstrated improved assessment and monitoring processes in relation to weight loss. Care planning documents demonstrated risks are identified, assessed and include individualised strategies and care interventions with review and monitoring to minimise and manage the risks. Staff demonstrated an understanding of the high impact and high prevalence risks associated with each consumer and the assessed strategies to manage and minimise risk to the consumer. Staff have received education and training in high impact and high prevalence risks.

The service demonstrated it has an organisational outbreak management plan, infection control and antimicrobial stewardship policies in place to guide staff practice. Staff demonstrated knowledge and understanding of infection control practices to reduce the spread of infection as well as practices to promote appropriate use of antimicrobials.. Staff have completed training in infection control practices and antimicrobial stewardship. The Assessment Team observed most staff wearing appropriate Personal Protective Equipment in line within current guidelines.

Based on the available evidence, summarised above, I find Requirements 3(3)(a), 3(3)(b) and 3(3)(g) are Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service was found Non-compliant in Standard 4 in relation to Requirements 4(3)(a) and 4(3)(f) following a site audit in July 2022 where it was unable to demonstrate:

* Safe and effective services and supports of daily living that met each consumers’ needs, goals and preferences.
* Meals were varied and of suitable quality and quantity.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Most consumers and representatives were satisfied with the supports of daily living the consumer receives and the activities on offer at the service, providing positive feedback about attending bingo, bus trips and concerts. While some consumers provided mixed feedback about lifestyle activities, they also said they choose not to participate in the group activities, and provided examples of other activities they engage in. Lifestyle staff demonstrated understanding of the consumers individual needs and preferences and the services and activities available to optimise the consumers independence and quality of life. Consumer documentation reflected all sampled consumers attendance and participation in activities, both group and individual, and their activities of interest and preferences. The service has appointed additional lifestyle staff and implemented new activities including one on one sessions. The lifestyle program is regularly reviewed and incorporates consumer and representative feedback from resident and relative meetings and other sources. The Assessment Team observed consumers participating in activities during the assessment contact.

Most consumers and representatives expressed satisfaction with the variety, quality and quantity of the meals. The service demonstrated it has processes in place to ensure consumers have input into the menu. For example, for the consumers who provided negative feedback in relation to the meals, management demonstrated they have obtained recipes from the consumers and are working with them to collect ingredients to incorporate the dishes into the menu. Staff described consumers are offered alternative meal options if they do not like what is being offered. Catering staff described how they keep dietary folders to ensure consumer dietary requirements are followed. Meeting minutes demonstrated there is a standing food focus agenda item where menu updates, planned actions and feedback are discussed. Feedback and complaints data demonstrated a decrease in complaints regarding food and hospitality and an increase in compliments since the previous site audit. The Assessment Team observed consumers eating and enjoying the meals during the assessment contact and menus in English and Russian displayed on dining tables. Management was observed engaging with consumers during meals and dietary folders were observed in the main kitchen.

Based on the available evidence, I find Requirements 4(3)(a) and 4(3)(f) are Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found Non-compliant in Standard 6 in relation to Requirement 6(3)(d) following a site audit in July 2022 where it was unable to demonstrate:

* Actions taken in response to complaints and feedback resulted in continuous improvement in quality care and services.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service demonstrated that complaints and feedback are reviewed and used to inform continuous improvement. Management described how they review feedback and complaints data monthly and discuss any identified trends and strategies for improvement. Actions for improvement are reviewed regularly, and ongoing feedback is sought and encouraged from consumers and representatives to establish the effectiveness of continuous improvement strategies. The service’s plan for continuous improvement detailed opportunities for improvement identified through feedback and complaints data, actions for improvement, timeframes, and progress updates on agreed actions. The services complaints and feedback register demonstrated a decrease in the number of complaints and an increase in the number of compliments since the previous site audit.

Based on the available evidence, I find Requirement 6(3)(d) 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was found Non-compliant in Standard 7 in relation to Requirements 7(3)(a) and 7(3)(d) following a site audit in July 2022 where it was unable to demonstrate:

* The workforce is planned and deployed to enable delivery of care and services to meet the needs of consumers.
* The workforce had completed their mandatory competencies, and processes were in place to monitor the completion of mandatory training.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service has recruited several roles including registered nurses, care staff and lifestyle staff. The service has implemented a new rostering system that has streamlined roster and allocation processes. The new roster system has improved the process for filling vacant shifts with internal staff and has reduced the services use of agency staff. Roster documentation reviewed demonstrated all shifts were filled and no vacancies for the two weeks prior to the assessment contact. Consumers and representatives provided positive feedback in relation to staffing levels and call bell response times. Staff were satisfied with the staffing levels, noting that staff were able to provide adequate and timely care to consumers, and provided positive feedback about the new rostering system. Call bell response times have decreased since the previous site audit, and call bell data demonstrates call bells are being responded to in a timely manner.

Most consumers expressed satisfaction that staff know what they are doing and are well trained. Staff provided positive feedback in relation to training provided and felt well equipped and supported by the service to perform their roles, and supported to requested additional training opportunities. Training records demonstrated most staff have completed mandatory training and management explained the monitoring systems in place, including internal reports that highlight non-compliance and training needs. The service has moved to an online training platform. Management described how they monitor training outcomes through ‘spot checks’ to ensure training is embedded into practice.

Based on the available evidence, I find Requirements 7(3)(a) and 7(3)(d) are 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 |
| 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 service was found Non-compliant in Standard 8 in relation to Requirements 8(3)(c) and 8(3)(d) following a site audit in July 2022 where it was unable to demonstrate:

* Effective governance systems in relation to continuous improvement, workforce governance, feedback and complaints, and regulatory compliance specifically restrictive practice requirements.
* Effective risk management systems in relation to assessment of pain, call bell systems, risks alerts, staffing levels and infection control practices.

At the April 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service demonstrated effective governance systems in relation to information management, continuous improvement, financial and workforce governance, feedback and complaints and regulatory compliance. Staff demonstrated understanding of the policies and processes that supported each of the governance systems. The service maintains a Plan for Continuous Improvement (PCI) that reflects a range of local and organisational improvements identified and actioned in response to consumer and staff feedback and complaints. Most actions in the PCI were observed to be closed with outcomes and the remaining actions actively being progressed. Regulatory compliance is managed at an organisational level, and any updates or changes to legislation and its policies and procedures communicated to staff at a service level. The service has reviewed the psychotropic register to ensure it is completed in line with restrictive practice legislative requirements. Staff have completed education in restrictive practices with the support of medical practitioners. The psychotropic register and clinical risk register are regularly reviewed, with any variances escalated. Review of the psychotropic register demonstrated the service is minimising the use of restrictive practices, which is supported by consumer’s medication charts. Management feedback, and a roster review confirmed, that the workforce is planned to facilitate the management of safe and skilled quality care and services for consumers. The service has an effective feedback and complaints process that defines and describes open disclosure. Staff demonstrated their knowledge of open disclosure when dealing with complaints from consumers and representatives.

The organisation demonstrated it has effective risk management systems in place. Management and staff demonstrated understanding of their obligations in relation to reportable and non-reportable incidents, and document review confirmed that the service maintains a regularly updated incident register. Clinical staff effectively demonstrated their knowledge of SIRS and correctly outlined their responsibilities based on their role. Management described the high impact and high prevalence risks for the service and this aligned with incident report documentation. The service has demonstrated it supports risk management and evaluates outcomes through audits and spot checks. I have found the service compliant in standards 2, 3 and 7 and it is my view the service has effectively addressed the deficits previously identified in the previous site audit, in relation to the risks associated with the assessment of pain, documented risk alerts, workforce levels and safe delivery of care, call bell system and infection control practices.

Based on the available evidence, I find Requirements 8(3)(c) and 8(3)(d) 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)