Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | John Curtin Aged Care |
| Commission ID: | 3310 |
| Address: | 5 Cushing Avenue, CRESWICK, Victoria, 3363 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 12 October 2023 |
| Performance report date: | 8 December 2023 |
| Service included in this assessment: | Provider: 207 John Curtin Aged Care Inc  Service: 2068 John Curtin Aged Care |

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 John Curtin Aged Care (**the service**) has been prepared by N Eastwood, 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 4 December 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not Compliant |
| **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** |

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.

Standard 3

* Requirement 3(3)(b) ensure individualised behaviour support plans are in place and evidence is available to support appropriate use of environmental restrictive practices.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Requirement 3(3)(b):

The service did not demonstrate effective management of restrictive practices. Four of 4 consumers’ files did not contain behaviour support plans and there was no consideration to environmental restraint where access was controlled.

Management did not identify consumers subject to chemical restraint, however, the psychotropic register reflected medications used for management of responsive behaviours. Management also confirmed they were not aware of obligations concerning the need of informed consent for restrictive practices and development of behaviour support plans and consumers and representatives have not been asked to sign a consent for environmental restraint.

The Assessment Team noted effective management of other high impact high prevalence risk areas. These included comprehensive post-falls assessment and monitoring, weight management with monthly monitoring and referral pathway for dietician or speech pathologist review, and wound management.

The Approved Provider submitted a response to the Assessment Team report with additional information and evidence of newly implemented assessments, risk indicators, notification to families of obligations relating to restrictive practices, behaviour support plan examples and strategies to support use of access passes.

I acknowledge the actions implemented by the service to address the deficits identified by the Assessment Team, however, note that these actions are in their infancy and provide evidence of initial steps toward compliance with this requirement. I am reassured that there is a considered approach to ensuring all consumers have appropriate behaviour support planning in place and there is awareness of obligations surrounding the use of environmental restraint.

With consideration to the available evidence, Approved Provider response and Assessment Team recommendations, I consider further time is required to evaluate and ensure actions and individualised planning occurs and is sustained in practice. As a result, I find requirement 3(3)(b) not compliant.

Requirement 3(3)(f):

Consumers and representatives were satisfied they have access and were referred to their medical officer and other health professionals as needed. Staff described the process and provided examples of results of referrals to other services. Clinical staff described making referrals through email and providing updates to management when a referral to a speech pathologist is needed. A review of care documentation demonstrated regular and ongoing consultations with medical officers, physiotherapists, podiatrists, dietitians, speech pathologists and other external and allied health providers.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 3(3)(f).

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 Assessment Team noted mixed feedback in relation to the quality and variety of meals. However, all consumers and representatives confirmed they were satisfied with the quantity of the meals provided. Staff demonstrated an understanding of consumer dietary needs and preferences and catering staff explained how changes to consumer needs and preferences were communicated to the kitchen. Management discussed improvement actions they have planned to enhance the dining experience, including developing the culinary skills of chefs and catering staff and gaining a better understanding of the regional foods preferred by consumers. There has been recent introduction of a hot breakfast twice a week with an aim to increase this until it can be offered daily.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 4(3)(f).

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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

Consumers and representatives were satisfied with outcomes from feedback and apologies were provided when things went wrong. Staff and management described the process when something goes wrong, however, did not recognise this as an open disclosure process. The service has policies and procedures to guide staff with complaints management and application of open disclosure included in the staff induction pack. Following feedback, management advised that open disclosure training was provided as part of the induction process and acknowledged that further training was required. The Assessment Team noted the service’s corporate governance material around open disclosure and noted that it provides an outline of open disclosure and links for further information and education.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 6(3)(c).

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)