Performance

Report

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| Name of service: | Kardinia Parkside Care Community |
| Service address: | 299 LaTrobe Terrace GEELONG VIC 3220 |
| Commission ID: | 4026 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 April 2023 to 4 April 2023 |
| Performance report date: | 4 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 Kardinia Parkside Care Community (**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 - 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 on 27 April 2023

# Assessment summary

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| 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** |

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)(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

This requirement was previously found non-compliant following a Site Audit on 2 March 2021 and again at an Assessment Contact on 15 July 2021. Deficits identified in these audits were responded to by the previous Approved Provider and related to the documentation of consumer care needs, using the service’s assessment and care planning process including a lack of consistency in communication of consumer’s care needs with handover and care planning documentation. The service was subsequently acquired by Opal Healthcare who have implemented actions to address the previously identified deficits.

At the current site visit the Assessment Team reviewed actions planned on the service’s plan of continuous improvement (PCI) dated 15 September 2021. The Assessment team noted the service has implemented the effective use of an electronic handover system with clinical staff updating consumer information, assessments, reviews and when clinical tasks are due. The PCI also indicated that staff readily access the electronic care document system, and a consumer list can be printed by care and clinical staff. Notwithstanding these improvements, the Assessment Team recommended that this requirement continues to be not met as the service was unable to demonstrate the planned actions related to completion of documentation for consumers subject to restrictive practice were completed.

The Assessment Team noted that not all the planned actions had been embedded in practice or reflected the services restrictive practice policy and best practice. Sampled documentation and interviews indicated the procedure for authorisations, assessment, care planning and review of chemical restrictive practice was not consistently implemented. Three consumer’s care files did not contain comprehensive assessments, planned interventions and evaluation of care related to the use of chemical restrictive practice.

The Approved Provider response indicated that all consumers identified by the Assessment Team have now been reviewed with relevant documentation updated to reflect the requirements related to use of chemical restrictive practice. To ensure best practice is maintained in the management of consumers subject to chemical restrictive practices the service has added the Assessment Teams observations to the current PCI, an alert has been added to each consumer’s electronic file which includes a prompt to implement nonpharmacological interventions prior to administration of ‘as required’ psychotropic medication. Team attendance at Behaviour Recording Chart and Support Plan training in addition to dissemination of education resources as well as a regular agenda item related to restrictive practice for nursing meetings has been initiated.

The Assessment Team also noted that most of the care files contained completed assessments and interventions related to skin integrity, falls risk, nutritional needs, and the individual’s complex care, such as diabetes management. Clinical staff were able to describe the process to complete a suite of assessments on the consumer’s initial entry to the service and the ongoing reassessment when a consumer has experienced a fall, a transfer from hospital or identification of a wound. Care staff explained that they report any changes they observe in the consumer’s condition to the nurse and document in the progress notes. The service’s ‘conducting assessments, care plans and observations’ policy provides clinical staff with clear processes of the expected assessment and care planning documentation to be completed.

It is apparent from the Approved Providers response that they have actively implemented a number of processes and planned strategies to address the concerns raised by the Assessment Team following the site visit of 3 and 4 April 2023. While it is acknowledged that the service will require time to ensure these strategies are embedded in practice, I am reassured that the actions to date reflect a commitment to maintaining compliance with this requirement is ongoing. As a result, and with consideration to the available information and Approved Provider response I have come to a different view than the Assessment Team and find Requirement 2(3)(a) now 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 |

Findings

This requirement was previously found non-compliant following a Site Audit on 2 March 2021 and again at an Assessment Contact on 15 July 2021. Deficits identified in these audits were responded to by the previous Approved Provider and related to to wound management, recognising, and responding to changes in consumers’ skin integrity and effective management of pain. The service was subsequently acquired by Opal Healthcare who have implemented actions to address the previously identified deficits.

During this site visit, the Assessment Team noted improvements in skin and wound care and pain management. However, the Assessment Team recommended that this requirement continues to be not met as the service was unable to demonstrate identification, assessment, management, minimisation, consultation, and evaluation of all chemical restrictive practice. The organisation’s restrictive practice policy last reviewed 21 February 2023, provided a robust process of assessing and applying restrictive practices with documentation completed in line with legislation, ongoing communication with the prescribing practitioner and ongoing review of each consumer in line with minimising the use of restrictive practice. However, the service did not demonstrate practice which aligned with their policy.

At the time of the site visit the Assessment Team considered that the service was unable to demonstrate that the use of chemical restrictive practice was minimised and the administration of psychotropic medication as a last resort. Not all consumers prescribed and administered psychotropic medication had been identified, assessed, or had a behaviour support plan developed to manage care needs in accordance with the service’s policy. The Assessment Team also identified inconsistencies with informed consent and accurate inclusion in the service’s monitoring register. When an ‘as required’ psychotropic medication was administered, evidence of evaluation for effectiveness was not consistently documented.

The Approved Provider response indicated they have reviewed all identified consumers following the Assessment Teams observations and corrected a number of identified gaps in documentation. The response also indicated that the services Plan of Continuous Improvement (PCI) has been updated to reflect improvements related to chemical restrictive practice as well as implementing practical strategies for staff, education, monitoring and ongoing agenda items for discussion and review. In its response the Approved Provider submitted detailed information regarding the updates and additions made to each identified consumer file, as well as evidence of consultation with representatives, general practitioners, and lifestyle staff members. Where there were specific concerns regarding the administration of psychotropic medication at the same time as analgesia the Approved Provider response provided additional context and information regarding the evaluation process at the service.

While the Assessment Teams observations reflected a number of concerns regarding the services management of chemical restrictive practice, the Approved Provider has been able to provide additional information which supports their approach to address the previously identified deficits.

The Assessment Team noted that where there was previous concern resulting in a non-compliance with this requirement, the service was able to demonstrate pain, wounds, pressure injuries and skin integrity issues are now managed consistently, pressure area care is maintained, and equipment is provided when needed. Wound documentation reviewed demonstrated clear instructions. Wounds were measured and dressed according to directions and photographs taken regularly. A registered nurse had oversight of the wounds. The service currently has no recorded pressure injuries. Pain was identified and actioned in a timely manner, a review of care files demonstrated appropriate pain charting and the implementation of a range of non-pharmacological strategies to support pain management in addition to analgesia. Consumers and representatives spoke positively of how the service manages skin integrity and wounds.

It is apparent from the Approved Providers response that they have actively implemented a number of processes and planned strategies to address the concerns raised by the Assessment Team following the site visit of 3 and 4 April 2023. As a result, and with consideration to the available information and Approved Provider response I have come to a different view and find Requirement 3(3)(a) now 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)