Performance

Report

**1800 951 822**

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| Name of service: | Korongee |
| Service address: | 264A Main Road GLENORCHY TAS 7010 |
| Commission ID: | 8083 |
| Approved provider: | Glenview Community Services Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 September 2022 to 21 September 2022 |
| Performance report date: | 28 November 2022 |

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 Korongee (**the service**) has been prepared by L. Malone, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 28 October 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

# 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.

* Ensure workforce planning, including staff number and mix, enables the delivery of safe and effective care to consumers including effective supervision to support behavioural management and staffing resources to provide assistance with activities of daily living.

# Standard 3

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| 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. | Compliant |

Findings

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with each consumer specifically in relation to the management of behaviours in dementia and weight management. I have considered the evidence presented in the assessment team report and the response of the approved provider and come to a different view.

The Assessment Team received feedback from representatives describing dissatisfaction with opportunities for meaningful activity, the level of dementia-specific training and knowledge of staff, and number of leisure and lifestyle staff members available.

Staff were able to describe the high-impact and high-prevalence risks related to consumer’s care and specific strategies to manage these including the management of behaviours related to dementia. Staff reported to the Assessment Team that due to insufficient staffing they are not able to consistently implement individualised strategies and provided examples of how care is impacted but staffing levels. I have considered this evidence more relevant to Standard 7 Requirement 7(3)(a) in making my decision.

Care documentation reviewed by the Assessment Team provided evidence that appropriate assessment of an individual consumer’s risks occur, strategies for managing risks are implemented and the effects of these interventions are monitored. Behavioural support plans were found to be current and demonstrated the involvement of other specialists and dementia consultants in managing behaviours.

I have considered observations made by the Assessment Team and reports of increased sleepiness in one consumer on prescribed psychotropic medication but note that at the time of assessment contact the consumer had been referred to their medical practitioner for medication review. In their response the approved provider stated communication with the medical practitioner has occurred since the assessment contact in relation to the use of psychotropic medications and provided further information about the use of ‘PRN’ or ‘as required’ psychotropic medication and the engagement of dementia specific services in assessment and management of consumers with behavioural symptoms of dementia. I have considered the Assessment Team’s evidence and in light of the approved providers response I am not satisfied it demonstrates ineffective management of high-impact, high-prevalence risk.

The Assessment Team reviewed care files of consumers who had lost weight and found some had no identified cause and had not yet been reviewed. A dietician was observed on site at the time of the assessment contact. The approved provider’s response notes nutrition and weight management as a focus of continuous improvement and outlines a number of actions and strategies implemented to date. For example, the Assessment Team found some inconsistencies in the documentation of risks and blood glucose parameters for consumers with diabetes. In their response the approved provider stated that blood sugar parameters are documented on the electronic medication management system and there are no known incidents related to blood sugar monitoring and the administration of insulin for diabetic consumers.

I have considered all available evidence and while I acknowledge the negative feedback of representatives in relation to opportunities for meaningful engagement, leisure and lifestyle staffing numbers and staff training in dementia-specific care, I have considered this in Standard 7, Requirements 7(3)(a) and 7(3)(d). I am satisfied evidence related to care documentation, observations on site and the response of the approved provider demonstrates that high-impact, high-prevalence risks are effectively managed. I find this requirement 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 7(3)(a) is Non-compliant:

The Assessment Team received feedback from consumers and representatives that staffing is not always sufficient to meet their needs. For example, delayed call bell response times especially at night, being assisted with evening tasks such as dressing in pyjamas in late afternoon, concerns with hygiene not being attended to and staff not providing appropriate supervision and prompting during personal care. Staff said although there are ‘float’ staff members available across the 12 houses they are not always available and described the adverse impact on consumers such as instructing consumers not to mobilise until assistance is available, being unable to prioritise personal grooming or cleaning tasks due to other care needs, ineffective supervision resulting falls or escalation of behaviours related to dementia such as wandering or aggression. Staff feedback presented under Standard 3, Requirement (3)(b) of the assessment contact report describes difficulty implementing individualised behavioural support strategies and escalation of behaviours in consumers with dementia due to a lack of supervision and staff availability.

Evidence in the assessment team report describes the service as consisting of 12 houses in a streetscape design of cul-de-sacs with 3 houses per cul-de-sac. Each house is home to 8 consumers all of whom are living with dementia. Each house is staffed by one staff member who attends to care duties, some cleaning and meal preparation. In their response, the approved provider notes that in addition 4 ‘floating’ staff and a care team leader are available to assist across the 12 houses with daily tasks. They also provided further information regarding nursing, leisure and lifestyle and management staff on site however no supporting evidence of staffing structure was provided for my consideration. In their response, the approved provider acknowledged at times some consumer’s care needs cannot be attended due to staff attending to other consumer’s needs.

In their response, the approved provider describes a targeted project to review workforce sustainability commenced in September 2022 following feedback on staffing from consumer and representatives. The project will include exploration of workforce challenges, model of service delivery, workforce mapping and upskilling, and other objectives. The approved provider describes various ways the board has sought input from staff and that some suggestions had been immediately implemented. The approved provider also submitted information regarding the engagement of volunteers to support consumers activities of daily living.

In relation to named consumers in the report, the approved provider relates some observations and feedback presented in the assessment team report to consumer’s preferences and behavioural presentations related to their dementia, however, did not submit supporting evidence for my consideration.

In consideration of all evidence presented to me, I persuaded by the evidence in the assessment team report in particular the consumer, representative and staff feedback. While I acknowledge the approved provider has identified a need for workforce review and the relevant planned strategies, these actions are yet to be fully implemented, evaluated or embedded into usual practice. I find Requirement 7(3)(a) Non-compliant.

I am satisfied the remaining assessed requirement of Standard 7 Human resources is Compliant:

The Assessment Team received feedback from consumers, representatives and staff about staff training and how they are equipped and supported to perform their roles and meet the outcomes required by the Quality Standards. While staff confirmed they have appropriate skill and experience to perform their role, some highlighted a need for increased dementia care training. In response to Assessment Team feedback, management described the various training opportunities made available to staff including dementia training. The Assessment Team’s observations of training schedules, the engagement of specialist training providers including dementia-specific organisations and staff attendance records align with management’s response.

I find Requirement 7(3)(d) 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 |

Findings

The Assessment Team found the service did not demonstrate effective risk management systems in relation to the use of psychotropic medications and consent for the use of chemical restrictive practice. I have considered the evidence available to me and have come to a different view.

The Assessment Team presented evidence related to identification of chemical restrictive practice and documentation of consent on the psychotropic register. Supporting examples are provided in the assessment team report of consumers for whom the use of the psychotropic medication was not recognised as a form of restrictive practice on the psychotropic register and others where consent to the use of the medication was not consistently documented. I note the assessment team report demonstrated this documentation deficit was rectified by management during the assessment contact. The approved provider’s response acknowledges the findings of the Assessment Team and describes relevant actions undertaken.

The Assessment Team found the service has an effective incident management system and acts to prevent adverse incidents, policies to prevent abuse and neglect, and supports consumers to live their best life and make choices involving risk.

I have considered the assessment team report and approved provider’s response. While I acknowledge the deficits in the psychotropic register I am not satisfied this demonstrates ineffective risk management systems related to the management of high-impact, high-prevalence risk. I find this requirement 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-2)