Performance

Report

**1800 951 822**

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| Name of service: | Mark Donaldson VC House |
| Service address: | 301 Galston Road GALSTON NSW 2159 |
| Commission ID: | 0955 |
| Approved provider: | RSL LifeCare Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 31 May 2023 to 1 June 2023 |
| Performance report date: | 5 July 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 Mark Donaldson VC House (**the service**) has been prepared by T Clerke, 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 22 June 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** |
| **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)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | 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

2(3)(c) - During a Site Audit conducted on 15 August 2022 to 17 August 2022, the service was found to not meet this Requirement. The rationale for the not-met finding included consumers and representatives stating they were not aware of care planning and assessments, had minimal involvement in their care planning and a medical officer not being involved in a consumer’s care. Monthly care plan reviews did not demonstrate involvement of consumers and representatives. Case conferences were not conducted annually or when a consumers’ condition changed.

The approved provider implemented improvements to address the non-compliance which included:

* Communication regarding how to access care plans sent to representatives via email.
* Communication to the registered nurses about referrals to the medical officer.
* All consumers have had a case conference and have been provided a copy of their care plan.
* The Assessment Team reviewed consumers identified during the previous performance assessment. All consumers still residing at the service had their issues addressed as part of their continuous improvement.

During this Assessment Contact, the service demonstrated that assessment and planning is based on a partnership with the consumer and others they wish to be involved and includes other health professionals. Most consumers and representatives expressed they were included in their assessment and care planning. Staff were able to describe ways they include the consumers and representatives and other health professionals such as via face-to-face conversations, telephone call, or via email. Documentation reviewed showed consumers and representatives and other health professionals are included in their assessments and care planning.

2(3)(e) - During a Site Audit conducted on 15 August 2022 to 17 August 2022, the service was found to not meet this Requirement. The rationale for the not-met finding included consumer dissatisfaction with personal and clinical care and changes to care needs are not consistently considered or documented.

The approved provider implemented improvements to address the non-compliance which included:

* Recommencement of the ‘Resident of the Day’ process.
* Case conferences offered to all consumers.
* Weekly reviews of clinical and lifestyle charts.

During this Assessment Contact, the service demonstrated that comprehensive review of care and services is conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals, or preferences of all consumers. Most consumers and representatives provided positive feedback and said they had been informed when there were any changes.

I am satisfied the service is compliant with requirements 2(3)(c), 2(3)(d) and 2(3)(e).

# 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

3(3)(a) - During a Site Audit conducted on 15 August 2022 to 17 August 2022, the service was found to not meet this Requirement. The rationale for the not-met finding included consumer dissatisfaction with personal care and continence care and blood glucose monitoring.

The approved provider implemented improvements to address the non-compliance which included:

* Review of care needs on all levels of the service.
* Case conferences offered to all consumers who raised feedback.
* Purchasing of equipment such as toilet slings for the memory support unit, tilt back shower chair and new hoist lifter with weigh function.
* Relocation of lifter battery chargers.
* The Assessment Team reviewed consumers identified during the previous performance assessment. All consumers still residing at the service had their issues addressed as part of their continuous improvement.

During this Assessment Contact, the service demonstrated that consumers get safe and effective personal care or clinical care that is tailored to their needs and preferences and is best practice. Consumers and representatives expressed satisfaction with the personal and clinical care and services that they receive. Staff knowledge around consumer care needs was sound. Documentation reviewed indicate the delivery of safe and effective care in line with the consumer’s needs that optimises their health and well-being.

3(3)(b) - During a Site Audit conducted on 15 August 2022 to 17 August 2022, the service was found to not meet this Requirement. The rationale for the not-met finding included high impact high prevalence risks are not effectively managed. Pressure relief charts, fluid balance charts, and blood glucose charts are not consistently completed. Pressure area care, fluid restrictions and diabetes management are not being attended according to assessed needs.

The approved provider implemented improvements to address the non-compliance which included:

* Care manager to oversee weekly review and update the high impact high prevalence risk register.
* Clinical indicators to be discussed during the weekly care planning and assessment meeting.
* Dignity of risk form is in place for Ms Heather Docker.
* Discussions held with staff regarding the importance of completing clinical charts.
* Implementation of a document which lists all consumer charting required to be completed to prompt staff.
* The Assessment Team reviewed consumers identified during the previous performance assessment. All consumers still residing at the service had their issues addressed as part of their continuous improvement.

# During this Assessment Contact, the service demonstrated that high impact high prevalent risks are being effectively managed. Management advised falls, chronic wounds, infections, unplanned weight loss and complex care as their high impact, high prevalent risks. Consumers and representatives provided positive feedback about their clinical care, and staff knowledge around high impact, high prevalence risks and strategies to mitigate those risks was sound. Observations and documentation showed these risks are being managed.

I am satisfied the service is compliant with requirements 3(3)(a) and 3(3)(b).

# Standard 6

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| 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

During a Site Audit conducted on 15 to 17 August 2022 non-compliance was identified in this Requirement with deficiencies in relation to the recording of complaints to evidence appropriate actions are regularly taken in response to complaints. Complaints related to personal care, staffing levels, temperature of food and consumers being bored.

During the Assessment Contact conducted on 30 May to 31 May 2023, the Assessment Team reviewed complaints and incidents documentation, consumer care records and interviewed consumers, representatives and staff.

The Assessment Team considered the service’s plan for continuous improvement (PCI) to address the non-compliance dated 3 February 2023 and a further updated PCI. The improvements relevant to this Requirement include:

* Recording all complaints in the organisation’s electronic feedback system.
* Both onsite management and the organisation’s support services have daily access to a summary of all complaints. The organisation has increased registered nurses access to the electronic feedback system so that all registered nurses can enter complaints and feedback directly, which has increased the reporting of complaints and feedback and subsequently increased the ability of the onsite management to respond to feedback.
* Management advised that they had spoken to consumers and representatives who have expressed that they are satisfied with the actions taken to address the feedback that they provided and remain satisfied that their feedback has remained resolved.

# The Assessment Team interviewed consumers and representatives who stated they were generally satisfied with the response from the service with regard to their complaints and feedback.

While the assessment team found that the approved provider is responsive to complaints, not all complaints about food and activities had been resolved to the satisfaction of consumers and representatives. The approved provider in their response provided further information that demonstrated their ongoing efforts and response to complaints.

I find the service is compliant with this requirement.

# 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

7(3)(a) - This requirement was found non-compliant following a Site Audit from 15 August 2022 to 17 August 2022. The service was unable to demonstrate 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. The non-compliance relevant to this requirement reported staff shortages resulting in consumers not receiving appropriate safe, patient centred, quality care and services.

The approved provider implemented improvements to address the non-compliance which included:

* Expand the recruitment strategy for Mark Donaldson House to include advertising for staff at the local businesses in Galston.
* Complete a review of care needs on each floor of the facility to review if additional resources are required or if there is a need for change to current processes to help optimise the delivery of care.
* Introduce a weekly review of call bell response times and strategies needed to improve efficiency in responding to call bells.

Most consumers and representatives did not have any complaints about staffing. Although some consumers did tell the assessment team that they did not feel there are enough staff.

The Assessment team found that the service has made improvements in the workforce and as such I am satisfied the service is compliant with the requirement.

7(3)(d) - Site Audit conducted on 15 to 17 August 2022 identified non-compliance in this Requirement with deficiencies in relation to the service’s training compliance, staff not completing mandatory training and low completion rates for modules relevant to staff duties.

During the Assessment Contact conducted on 30 May to 31 May 2023, the Assessment Team reviewed staff onboarding and training records, mandatory training and competencies completed and conducted consumers, representatives, and staff interviews.

The approved provider implemented improvements to address the non-compliance which included:

* The service has implemented a plan for each staff member to have a shift dedicated to completing their mandatory training resulting in a 30% increase in the completion of mandatory training to date.
* Staff reported at staff meetings and through verbal feedback that having time dedicated specifically to training has increased their capacity to complete training modules.
* Mandatory training days were scheduled in January 2023 to capture staff that need to complete their annual mandatory training modules.
* Ongoing monitoring was commenced using reports to management team with daily updates about education completion rates and highlights the names of staff that still need to complete mandatory training modules which assists with follow up.
* The organisation’s support services also have access to the facility's mandatory education completion rates and assist with monitoring and follow up with the facility.
* Training plan from August 2022 reviewed by the Assessment Team provided a list of mandatory training and other education to be completed by September 2022.

The Assessment team found that staff attendance at mandatory training has improved since the time of the site audit.

I am satisfied the service is compliant with the requirement.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| 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 |

Findings

8(3)(a) - This Requirement was found non-compliant following a Site Audit from 15 August 2022 to 17 August 2022. The service was unable to demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The non-compliance relevant to this requirement reported consumers are not engaged in the evaluation, development and delivery of services. Minimal consultation was occurring in their assessment and planning, and many had not attended case conferences to give feedback about their care and services.

The approved provider implemented improvements to address the non-compliance which included:

* Provide all consumers and their representatives with a copy of their care plan to review and provide feedback.
* Recommunicate to all consumers and their nominated representatives how to obtain further copies of their care plans when desired.
* Ensure all consumers named in the re-accreditation Site Audit report have been offered the opportunity to participate in a case conference with their authorised representative to review their feedback and the consumers current care needs and what strategies are needed to optimise the delivery of care for the consumer.
* The care manager will also complete a consumer allocation list for all other consumers not named on the Site Audit report and request the allocated registered nurse to follow up with the consumer and their authorised representative to arrange their annual case conference and additional case conferences as required.

The Assessment team found consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

8(3)(c) - This requirement was found non-compliant following a Site Audit from 15 August 2022 to 17 August 2022. The service was unable to demonstrate effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance and feedback and complaints. The non-compliance relevant to this requirement reported there was a lack of clinical oversight and governance.

The approved provider implemented improvements to address the non-compliance which included:

* Recommunicate to all staff and consumers current staffing structures and how they are designed to support and provide safe and effective care.
* Provide consumers and representatives and staff advice on strategies that have been implemented in response to feedback about staffing levels and how further feedback can be provided if required.
* Revise the quality meeting agenda to ensure clear records of what feedback has been obtained from consumers and representatives each month, actions in place in response to feedback and consultation with complainants about options to address the feedback they have provided.

The Assessment team found that there are effective governance systems at the service level in relation to workforce governance, regulatory compliance in relation to SIRS, incident management system and continuous improvement relating to feedback and complaints.

I am satisfied that the service is compliant with 8(3)(a) and 8(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)