Performance

Report

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| Name of service: | Mark Moran at Little Bay |
| Service address: | 1420 Anzac Parade LITTLE BAY NSW 2036 |
| Commission ID: | 0804 |
| Approved provider: | Mark Moran at Little Bay Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 May 2023 to 3 May 2023 |
| Performance report date: | 7 June 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 Moran at Little Bay (**the service**) has been prepared by J Durston, 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

# 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 5** Organisation’s service environment | **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)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirement 1(3)(f). The service was unable to demonstrate that consumer privacy is being respected and their personal information is kept confidential.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service has implemented improvements in response to the non-compliance raised in the 2022 Site Audit report. Improvements include delivery of a new training module on maintaining consumers’ privacy and dignity, with 93 staff completing the training since September 2022.

The Assessment Team found interviews with consumers, representatives and staff, observations and review of documentation, all showed consumer privacy is being respected and their personal information is kept confidential. One consumer advised staff respect her privacy by knocking before they enter her room and by having her personal care needs attended by female staff only, as is her preference.

Results from a recent consumer satisfaction survey demonstrated a rating of 88.2% for resident's dignity being respected and a score of 93.8% for resident’s privacy being respected. Staff were able to describe how they assist to maintain the privacy of consumers, and a new electronic system to the doors of the serveries and nurses’ station with swipe card access.

Accordingly, I find the Requirement 1(3)(f) is compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirements 2(3)(b) and 2(3)(d). The service was unable to demonstrate that care assessment and planning always reflected consumers’ needs and preferences in the areas of diabetes management, wound care and pressure injury care. The service was also unable to demonstrate that the outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and services plan that was readily available to them.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service implemented improvements in response to the non-compliance raised in the 2022 Site Audit Report.

In relation to Requirement 2(3)(b), the Assessment Team identified improvements including, the service has commenced a monthly clinical practice audit. Staff training was delivered to registered nurses and enrolled nurses that focused on consumer preferences in the delivery of care, wound management, skin integrity, pain management, bowel management and diabetes management. The service has employed an occupational therapist to support the physiotherapy team.

The Assessment Team reviewed the clinical care of all consumers identified in the 2022 Site Audit and found the service had taken effective actions and made improvements that addressed the gaps identified regarding Requirement 2(3)(b).

In relation to Requirement 2(3)(d) The Assessment Team identified improvements including, all consumers are given the residents’ handbook on entry to the service, which explains the process of partnering in care, and how to access care plans. Care planning review occurs in annual case conferences and the admission case conference held within 2 weeks of entry to the service. The resident of the day program ensures each consumer’s care is reviewed monthly and discussed with consumers and representatives and care plans are offered to them.

The Assessment Team found consumers and representatives confirmed they had been involved in case conferencing and had been offered a copy of their care plan. Care and service documentation showed discussions around care have been occurring, and staff were able to explain how they keep consumers and representatives updated with any changes to their care.

Accordingly, I find the Requirements 2(3)(b) and 2(3)(d) are 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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirements 3(3)(a) and 3(3)(e). The service was unable to demonstrate that each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and well-being. Some consumers and representatives raised concerns about personal hygiene care and appropriate review of psychotropic medications. The service was also unable to demonstrate there was an effective process to ensure consumer information is documented accurately and is communicated within the organisation, and with others where responsibility is shared.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service has implemented improvements in response to the non-compliance raised in the 2022 Site Audit Report.

In relation to Requirement 3(3)(a) the Assessment Team identified improvements including, the provider has introduced auditing of its clinical practices through the monthly clinical care audit, which covers personal care, complex care, incident and infection, risk management and psychosocial well-being. Gaps identified in the 2022 Site Audit have been analysed and ongoing training has and continues to be delivered to registered nurses and endorsed enrolled nurses. Training and education was addressed in Requirement 2(3)(b). The provider proposed the clinical quality and risk committee (CQRC) introduce additional audits for wound care, pain management, bowel management, medication management and complex health care.

The Assessment Team received feedback from sampled consumers, representatives and staff, reviewed consumers’ care and services documentation and identified that overall issues from the 2022 Site Audit have been addressed for personal care and psychotropic medication. However, some gaps in relation to wound, pain and medication management were identified. These were discussed with management during the Assessment Contact, they promptly followed up with consumers and staff, and the issues were effectively addressed.

In relation to Requirement 3(3)(e) improvements identified include, the revision of handover sheets to ensure a consistent follow-up communication with families regarding any changes in care. The clinical team delivered education to relevant staff and a memorandum was published in September 2022 reinforcing effective communication with all registered and enrolled nurses.

The Assessment Team found that review of documentation, observation of communication procedures and interviews with staff and others where responsibility for care is shared showed information about the consumers’ condition, needs and preferences is effectively documented and shared. This was confirmed by a medical officer attending the service, a physiotherapist employed by the service during the Assessment Contact, and review of documentation that demonstrated effective communication between the service, hospital and general practitioner regarding the care needs of a consumer discharged from hospital.

Accordingly, I find the Requirements 3(3)(a) and 3(3)(e) compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirement 5(3)(b). The service was unable to demonstrate the service environment was kept clean, safe and well maintained. There were gaps in relation to safety and cleanliness of the service environment, and hazards and maintenance needs were not always reported by staff in a timely manner.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service has implemented improvements in response to the non-compliance raised in the 2022 Site Audit Report. Improvements include, development of a pest control policy including monthly inspections of the internal and external environments and timely treatment when required. Maintenance and repair of the outdoor courtyard on the ground floor was completed. External window cleaning was added to the preventive maintenance schedule. A workplace health and safety (WHS) ‘walk through ‘audit is conducted monthly by WHS staff. Deep cleans of consumer rooms and common areas has increased to occur quarterly, and electronic access system was installed on doors to serveries, nurses’ stations and treatment rooms to ensure consumer safety.

The Assessment Team found review of documentation, interviews with staff, consumers and representatives and observations made by the Assessment Team during the Assessment Contact showed the service environment is kept clean and safe and is well maintained. One representative commented that the external environment, including the courtyards and gardens, is much cleaner than it has been in the past. Meeting minutes from a resident meeting held in November 2022 were reviewed and showed consumers are satisfied with the cleanliness and maintenance of the service environment. During the initial tour and throughout the Assessment Contact, consumer’s rooms were observed to be neat and tidy and common areas including lounge and dining rooms on each level were clean. Outside courtyards and gardens were observed to be free of rubbish and well maintained

Accordingly, I find the Requirement 5(3)(b) is compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirement 7(3)(b). The service was unable to demonstrate workforce interactions with consumers were kind, caring and respectful.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service has implemented improvements in response to the non-compliance raised in the 2022 Site Audit Report. The Assessment Team identified improvements including, the service has implemented mandatory and ongoing education and training on maintaining consumers’ dignity and respect, and the topic is also discussed during staff appraisal process. Staff were provided with a copy of the Commission’s Code of Conduct for Aged Care.

The Assessment Team found review of documentation, interviews with staff, consumers and representatives and observations showed interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Observations made by the Assessment Team during mealtimes included staff communicating with consumers in a kind and respectful manner and using consumers’ preferred names when addressing them. Staff were observed providing end of life care for a consumer in a kind, respectful and dignified manner. One consumer advised they require assistance multiple times per night and that the staff are very good and always come and help them.

Accordingly, I find the Requirement 7(3)(b) is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship. 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Following a Site Audit conducted from 12 to 14 September 2022 and 19 to 21 September 2022, the service was found to be non-compliant with Requirements 8(3)(b), 8(3)(d) and 8(3)(e). The service was unable to demonstrate that the governing body promotes a culture of safe, inclusive and quality care and services, and the board was unable to demonstrate a clear commitment to inclusivity and diversity. The service did not demonstrate effective risk management in relation to managing high impact and high prevalence risks associated with the care of consumers and managing and preventing consumer incidents, and there was not an effective clinical governance framework in place for effective antimicrobial stewardship.

An Assessment Contact was conducted on 2 to 3 May 2023. The Assessment Team found the service has implemented improvements to in response to the non-compliance raised in the 2022 Site Audit Report.

In relation to Requirement 8(3)(b), the Assessment Team identified improvements including, the board approved the recruitment of an additional clinical care manager, in response to staff feedback, to provide overall oversight and support to clinical managers and registered nurses. Documentation showed the board promotes inclusivity through diversity training and education in areas such as supporting and encouraging the recognition of Aboriginal consumers and inclusivity. The board conducts face to face meetings every 3 months with consumers and staff at the service to communicate and promote cultural values, as do the resident handbook, emails, and monthly newsletters. The board and CEO receive daily and monthly reports on incidents, issues and risks, and the plan for continuous improvements for the month.

In relation to Requirement 8(3)(d), The Assessment Team identified improvements, including, the board approved a salary increase to attract and retain experienced registered nurses to effectively manage high impact high prevalence risks. Documentation showed retention rates have increased. The board works with the management team to monitor trends in monthly audit reports to formulate action plans implement improvements in areas such as clinical care, food, and lifestyle against industry benchmarks. The board, in conjunction with the management team, formulate action plans to implement improvements and monitor trends. The board meets monthly which the clinical operations executive attends. The director of nursing attends 3 monthly and meets monthly with managers. Additional clinical managers have been employed to provide a higher support to staff, registered nurses and focus on incident prevention strategies. Another clinical care manager has overall oversight to support clinical managers. The board approved the recruitment of physiotherapists to implement preventions strategies to reduce falls

The management team supervise and monitor staff on a daily basis and conduct ongoing surveys to evaluate staff performance and areas of risk and concern.

Documentation and care plans show incidents are logged and reviewed by the management team, clinical care manager and registered nurses who provide a report of details to the board for review on a monthly basis. Incidents are investigated and analysed to identify trends and causes and implement risks prevention and mitigation strategies

In relation to Requirement 8(3)(e), the Assessment Team identified improvements including, staff training and education delivered to reduce inappropriate use of antibiotics, promote effective management and prevention of infections and to minimise the use of restraints. The management and clinical teams review antimicrobial stewardship data and provide recommendations to the board. The Assessment Team found documentation showed consumers are consulted about risks and mitigation strategies to assist them to live their best lives and about risks when they or their family request the use of restraint.

Consumers with behaviours of concern are assessed and alternative behaviour support strategies are investigated and tried before the use of chemical restraint in consultation with consumers, their representatives, psychiatric and dementia specialist services, general practitioners and health professionals. Chemical restraints are reviewed 3 monthly with a view to reducing or ceasing the use of psychotropic medication where possible. The board monitors restraint reports in monthly clinical and management meetings. All Serious Incident Response Scheme (SIRS) notifications are reported to the board in the monthly operations report and the board provides feedback to the management team about how mitigation strategies are to be implemented and follows up on incident outcomes.

The Assessment Team found documentation showed the board receives regular and detailed information on operational performance from the management and clinical teams in relation to clinical indicators and areas for improvement. The clinical governance framework shows the antimicrobial stewardship program is overseen by the medication advisory committee which provides monthly reports to the board. An audit on antibiotic usage is conducted every 3 months and analysed against industry benchmarks to inform improvement strategies.

The service demonstrated it has effective policies and processes in place for preventing, managing and controlling infections and antimicrobial resistance and ongoing implementation strategies to reduce the inappropriate use of antibiotics. The service has 3 Infection prevention and control (IPC) leads who provide monthly monitoring of antimicrobial stewardship and infection control.

Accordingly, I find the Requirements 8(3)(b), 8(3)(d) and 8(3)(e) 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)