Performance

Report

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| Name: | Navorina Nursing Home |
| Commission ID: | 2744 |
| Address: | 5-9 Macauley St, DENILIQUIN, New South Wales, 2710 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 July 2024 to 18 July 2024 |
| Performance report date: | 22 August 2024 |
| Service included in this assessment: | Provider: 1457 The Deniliquin Nursing Home Foundation Ltd  Service: 1100 Navorina Nursing Home |

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 Navorina Nursing Home (**the service**) has been prepared by Therese Solomon, 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 9 August 2024.

# 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 Compliant** |
| **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 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not Compliant** |

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.

Requirement 2(3)(e)

* Ensure 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.

Requirement 3(3)(a)

* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs and optimises their health and well-being.

Requirement 3(3)(b)

* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.

Requirement 8(3)(c)

* Ensure effective organisation wide governance systems, specifically related to feedback and complaints management.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices, specifically related to the management of high impact and/or high prevalence risks.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement 1(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including scheduling education and training for staff related to cultural safety, engaging 2 community visitors with Italian heritage to visit consumers at the service and purchase a translator application to facilitate communication between staff and consumers.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found the service was treating consumers with dignity and respect with their identity, culture and diversity valued.

Consumers and/or representatives provided positive feedback in relation to consumers being treated with dignity and respect. Staff were aware of consumer preferences in relation to their identify, culture and diversity, and adjusted care and service delivery in line with those preferences. The Assessment Team observed staff speaking about consumers in a respectful manner and observed staff interacting with consumers in a respectful and dignified manner throughout the Assessment Contact.

# 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 |
| 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 |
| 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. | Not Compliant |

Findings

The service did not demonstrate that 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.

The Assessment Team identified care and services plans are not consistently updated or reviewed when there is a change in a consumer’s condition or needs. Incident investigations are not consistently comprehensively completed with limited information related to the cause of the incident. Due to limited information related to the cause of the incident, interventions and strategies are not consistently implemented to minimise the risk of reoccurrence, ensuring consumer safety.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance, including reviewing assessments and care plans, engaging an acting clinical care manager, employ a full-time quality manager and engaging an external training to deliver training.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found non-compliant.

Requirement 2(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including initiate a full review of all care plans ensuring they are individualised and reflective of the consumers current needs and goals.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found 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.

Care planning documentation demonstrates evidence of assessment and planning for consumers. Risks to the consumer's health and well-being are identified upon admission and informs the delivery of safe and effective care and services. All consumers entering the service are assessed for risks and risk mitigation strategies are put in place.

Requirement 2(3)(d) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including ensuring all consumers and/or representatives received a copy of their summary care plans, updated the resident handbook to include information related to consumer care plans and how to obtain a copy.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found 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.

Consumer care and service records show the outcomes of assessment and planning are being communicated to consumers and/or representatives. Consumers and/or representatives confirmed the outcomes of assessments and planning are communicated to them, and that they receive a copy of their care and service plan. Staff confirmed they inform consumers of the outcomes of assessments and provide them with a copy of their care plan. Consumers and/or representatives stated they were actively involved in the care planning process and said they could get a copy of the care plan if they wanted one.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

The service did not demonstrate each consumer received safe and effective personal and clinical care that was tailored to their needs and optimised their health and well-being.

Feedback from most consumers and/or representatives was positive in relation to care consumers receive, however, the Assessment Team identified deficits in diabetes management, catheter care, pain management and restrictive practice. Documentation reviewed and discussions with management show the organisation’s related policies and procedures are not consistently followed and are not based on best practice guidelines. Personal and clinical care have not been tailored to consumer needs and has not optimised their health and well-being.

In relation to diabetes management, a review of the electronic care management system shows there is inconsistencies between the instruction in the diabetic management plan, care plan and blood glucose level recording chart.

In relation to pain management, a review of documentation showed consumer pain have not been monitored consistently, reducing the ability to review if his pain management has been effective. Care plans do not contain strategies to guide staff in managing consumer pain.

In restrictive practices, the services did not identify that consumers are subjected to environmental restraint due to a keypad placed on the front door, restricting consumer movement. Consultation and consent did not occur with consumers and/or representatives, identifying and acknowledging the restraint.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance, including ongoing education and training on restrictive practices for all staff, review and update policies and procedures.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found non-compliant.

The service did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer.

The Assessment Team identified deficits in the management of high impact and high prevalence risks associated with the care of consumers, including wound management, nutrition and hydration and behaviour management. The organisation’s policies and procedures have not been followed consistently.

In relation to wound management, wound care documentation was not consistently updated and completed, with inconsistency noted with wound photography and evaluation. Wound care directives were not consistently followed by clinical staff, and for some consumers limited evidence was found to support care directives.

In relation to weight loss, consumer documentation and monitoring charts was not consistently completed and strategies to reduce weight loss was not consistently followed. The service has policies and procedures in place relating to nutrition and hydration, as well as weight loss prevention and management. However, these were brief and did not provide clear guidance to staff.

Review of documentation related to behaviour support shows that triggers for behaviours are not always identified, and staff had limited knowledge of how to access behaviour support plans.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance, including education and training for all staff on wound management, weight loss and falls management.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |

Findings

Requirement 4(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including enrolling all staff in a program designed to assist staff with supporting consumers living with dementia, engaging 2 community visitors with Italian heritage to visit consumers at the service and purchasing a translator application to facilitate communication between staff and consumers.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found consumers gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.

Consumers and/or representatives stated consumers are provided with opportunities to engage in activities they enjoy, and that activities are adjusted to accommodate their needs and abilities.

The lifestyle manager showed the Assessment Team activity calendars that were also observed in consumer rooms. The manager could describe the interests of many consumers, and a range of activities that had been implemented to support consumers with individualised needs and preferences. Consumer needs and preferences were observed in care plans, and documentation confirmed activities are consistently attended.

# 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 |

Findings

Requirement 7(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including ensuring all call bells are working.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found 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 service has an electronic rostering system that enables unfilled shifts to be identified and filled. Management advised that until recently, staff had been able to individually access the rostering system and amend rosters without the knowledge of the service. This resulted in changes to shifts, and often lead to staff shortages. Management has immediately addressed this by restricting access to the rostering system and designating rostering to the administration team only.

Consumers and/or representatives stated the service has enough staff, and when they required assistance would use their call bell, and staff would attend promptly.

The Assessment Team observed staffing in the memory support unit and noted lifestyle staff and care staff interacting with consumers. Lifestyle staff advised that activities are inclusive of everyone, and those consumers who choose or who are unable to participate in group activities receive individualised activities such as pet care, jigsaws or a bus drive in the country.

Care staff and clinical staff reported the service has enough staff most of the time, however the service can experience shortages during times of unexpected leave. The service uses agencies to fill registered nurse vacancies ensuring 24-hour coverage of registered nurse services and has a pool of casual care staff which are contacted when unfilled shifts are identified.

# Standard 8

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| Organisational governance | |  |
| 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. | Not 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. | Not Compliant |

Findings

The organisation demonstrated compliance with information management, continuous improvement, financial governance, workforce governance and regulatory compliance. However, the organisation did not demonstrate effective organisation wide governance systems in relation to feedback and complaints management.

The organisation currently records and manages consumer care planning information on the electronic care management system. The system has the capacity to record consumer care plans, progress notes, and enable electronic messages to be sent to staff. However, management advised that the current electronic care management system will be replaced shortly due to limitations presented by the existing system.

Management advised that continuous improvement is identified through feedback and complaints, information gathered from the consumer advisory committee, and through assessing areas identified as being non-compliant. The organisation provided the Assessment Team with the plan for continuous improvement, which detailed areas of improvement and targeted completion dates.

The organisation demonstrated they have effective financial management and reporting systems in place, to manage finances and resourcing needed to deliver safe and quality care to consumers. Management advised how expenditure was undertaken at the organisation, including the upgrading of equipment such as the call bell system, and the purchase of fit for purpose indoor and outdoor furniture endorsed by consumers.

The organisation is currently undergoing significant changes to key personal, training, and reporting; and this has resulted in changes that have addressed non-compliance identified at the last assessment; including training for all staff on Serious Incident Response Scheme, and the preparation of a draft internal Serious Incident Response Scheme escalation policy.

Management reported all incidents are recorded into the electronic care management system and are reviewed by the clinical team and CEO to determine if a Serious Incident Response Scheme notification is required. Management acknowledged that there are still areas for improvement within in Serious Incident Response Scheme reporting, however the organisation is committed to ongoing staff training and the reporting of incidents. All staff advised that they had undertaken Serious Incident Response Scheme training.

The organisation collects and records feedback and complaints and will use it to improve care and supports. The organisation encourages feedback and complaints, through various avenues including the Consumer and Representative Committee and the Consumer Advisory Committee.

While the organisation acknowledged the concerns raised by the Advisory Committee and provided attendees a response addressing each matter the organisation could not demonstrate that concerns raised by the Consumer and Representative group were considered by the organisation.

It was noted that the organisation did not include feedback and complaints as a standing agenda item for Board meetings, nor was feedback and complaints incorporated into the meetings. Management acknowledged improvement could be undertaken and have noted this in the plan for continuous improvement. The organisation has a feedback and complaints policy and is currently evaluating a suite of aged care policies and procedures for purchase to replace existing policies.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance, including purchasing a new suite of aged care policies and procedures and appointing a Director of Care and a Quality Manager.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(c) is found non-compliant.

The service did not demonstrate effective risk management systems and practices, specifically related to the management of high impact and/or high prevalence risks.

The organisation discusses high impact and/or high prevalence risks including Serious Incident Response Scheme risks at the Clinical Governance Committee meetings, which is chaired by the clinical lead of the Board. Management demonstrated that high impact and/or high prevalence risks including falls, infection, and choking are captured by the organisation, and these had been incorporated into graphs for ease of identification. However, this information is not forwarded on to the Board for review. In addition, it was noted that information discussed by the Clinical Governance Committee was not always presented to the Board for consideration.

All clinical staff and care staff advised that they have completed training in abuse and Serious Incident Response Scheme. Management reported that incidents are recorded into the electronic care management system, and that the clinical team and the CEO are alerted of incidents. All incidents are now reviewed, and if requiring Serious Incident Response Scheme notification, then these are entered into the Serious Incident Response Scheme database.

The organisation demonstrated that consumers were supported to live their best life.

The organisation logs all consumer incidents into the electronic care management system and has now provided access to all staff to enable the recording of staff related incidents into the system as well. All incidents including infections, Serious Incident Response Scheme incidents and risks are discussed and considered by the Clinical Governance Committee.

The organisation has identified and responded to, the omission of a risk management plan. The Board is currently reviewing the draft document, and training has been provided to Board members on risk management. The organisation has an incident management policy and is currently evaluating a suite of aged care policies and procedures for purchase to replace the existing policy.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance, including implementing a new mechanism to ensure accurate reporting, discussion and strategy for managing high impact and/or high prevalence risks.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found non-compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)