Nazareth House Wynnum

Performance Report

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**Commission ID:** 5219

**Provider name:** Nazareth Care

**Assessment Contact - Site date:** 26 April 2022 to 27 April 2022

**Date of Performance Report:** 23 May 2022

# Performance report prepared by

Kimberley Reed, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(a) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(f) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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 Contact - Site report received 20 May 2022.
* other information and intelligence held by the Commission in relation to the service.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team did not assess all Requirements in this Standard therefore an overall summary or compliance rating is not provided.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(e) Compliant

*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 contact report documented deficiencies in the review of care and services relating to wound care and regular care plan review processes. While I acknowledge wound care documentation required areas of improvement, it is my decision wound care was being provided and there was no consumer impact based on the deficiencies in wound care documentation. The Assessment contact report identified care plans had not been reviewed every three months in line with the service’s processes. While I acknowledge the service has established processes for care plans to be reviewed every three months, I am not convinced that the lack of care plan review has resulted in poor care for consumers.

Consumers considered their care needs were reviewed regularly and provided positive feedback in relation to the delivery of care and services. Review of care plans demonstrated care plans were reviewed on a regular basis and when circumstances changed for the consumer. These changes included falls, skin tears, pain and wound care. Registered staff were aware of the requirement to update care plans when circumstances changed for the consumer. Care staff provided feedback they would inform registered of any changes required to consumer care needs.

The Assessment contact report evidenced eight consumers with wounds did not have evidence to support a weekly review of their wounds including photographs, measurements and descriptions of their wounds. While I acknowledge regular review of wounds is considered best practice, the Assessment contact report does not evidence wounds are not healing, or that wound care is not provided in accordance with wound care plans.

The Approved provider in its written response to the Assessment contact report has committed to improvements in wound management including wound reviews being added to the weekly clinical governance meeting, and the oversight of wound care is the responsibility of the Clinical Care Coordinator. Clinical governance meeting minutes were included in the Approved provider’s response which detailed the requirement for weekly photographs of wounds with measurements, the reporting of chronic wounds that have existed for over one month and the referral process to wound specialists. It is my decision these actions are sufficient to address the deficiencies identified in the Assessment contact report in relation to wound care.

Care plan review processes were identified as delayed and the Assessment contact report identified 34 care plans had not been reviewed every three months, as per the service’s processes. Consumers were monitored for changes and when incidents occurred, and daily review of progress notes occurred. The service also had a weekly review of consumers process occurring and handover notes were also monitored. Given this level of monitoring for consumers, I am not convinced the lack of regular care plan review has resulted in a lack of appropriate care delivery for consumers.

The Approved provider in is response to the Assessment contact report evidenced the completion of all overdue care plan reviews, the inclusion of care plan reviews at the weekly clinical governance meeting and the oversight of care plan reviews to be undertaken by the Clinical Care Coordinators. Memorandum sent by the Clinical Care Coordinator evidenced registered staff were instructed regarding the need for care plan reviews every three months and education was provided to registered staff in relation to the electronic system used by the service to track care plan reviews. Evidence was also provided in the Approved provider’s response to indicate there were no care plans overdue at the time of their response. It is my decision these actions are appropriate to address the deficiencies in relation to care plan reviews.

Actions had been taken in response to Non-compliance identified in this Requirement at the Site audit conducted on 18-20 October 2021. Actions have included the completion of restrictive practice documentation for consumers requiring restrictive practices, this documentation included assessments, consents and reviews. For consumers requiring psychotropic medication, assessments, authorisations and care plans were reviewed every three months. Medical officer review also occurred to assess the ongoing need for the medication. A register has been complete for consumers requiring chemical restraint, the register contains prompts in relation to medical officer review dates. Consumers requiring mechanical or environmental restraint had documented evidence of review of the need for restraint had occurred within the last 12 months. A review by the pharmacist has occurred to identify if prescribed medication constitutes chemical restraint, resulting in a prompt for medical officer review and authorisation. Registered staff are required to notify management of any newly prescribed psychotropic medication. These actions have been appropriate to address the deficiencies in this Requirement identified at the site audit on 18-20 October 2021.

Based on the information detailed above, it is my decision this Requirement is now Compliant

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Assessment Team did not assess all Requirements in this Standard therefore an overall summary or compliance rating is not provided.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*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.*

Consumers and representatives provided positive feedback in relation to the delivery of care and services to consumers. Documentation demonstrated each consumer received safe and effective personal or clinical care which was best practice, tailored to the consumers’ needs and optimised their health and wellbeing. Care staff demonstrated an understanding of individual consumers’ personal and clinical care needs. Actions have been taken to address the deficiencies identified in this Requirement at the Site audit on 18-20 October 2021.

Care and service plans were linked to best practice models and included a range of risk-based assessments. Consumer files which were reviewed reflected individualised consumer care which was both safe and effective. Care delivery review included catheter care and diabetes management. Clinical management stated they ensured care delivery was best practice by consulting the service’s policies and referring consumers to appropriate health care specialists. Clinical care delivery is monitored through daily review of progress notes, referral of concerns to medical officers and the review of monitoring records. Clinical indicators and wound records are reviewed monthly by clinical management.

The organisation had policies, procedures, guidelines and flowcharts for key areas of care including but not limited to, restrictive practices, skin integrity and pain management, all of which are in line with best practice. Staff had access to this information via the organisation’s intranet and hard copy information. The service had systems and processes to ensure consumers receive safe and effective personal and clinical care, including clinical audits, whole of service audits and training was available to support best practice. Monthly clinical indicator reports identified the service trends, analyses and responds to clinical indicators, incidents and risks. Clinical indicators were discussed at staff meetings and were used to identify improvements in the delivery of consumer care. The service participated in medication reviews for consumers, which are conducted by the consumers’ Medical officers and a pharmacist every three months or on referral.

The following actions have been taken to address the Non-compliance in this Requirement, identified at the Site audit on 18-20 October 2021. The service has documented policies and procedures to support the management and minimisation of the use of restraints. The policy includes information on the types of restraints, assessment and monitoring of consumers on restraints and alternative strategies to be used in place of restraints. Restraint management has been added to clinical governance and management meetings as a standing agenda item, whereby the effectiveness of planned interventions and changes to legislation and policy are discussed. Consumers requiring restraint are considered for potential referrals to community dementia services. The service developed a tool for self-assessment and recording consumers receiving psychotropic medications, this was observed to be completed for consumers receiving psychotropic medications from November 2021 to April 2022. Evidence was provided to demonstrate a three-monthly review of psychotropic medication.

Additional education and training were provided in relation to restraints management, assessment and care planning, informed consent, restraint review and monitoring, relevant restraint legislation and minimisation of restraints for treatment of behaviours. Training records supported the delivery of these topics. Care documentation for seven consumers prescribed a chemical restraint, documentation review supported restraint authorisations, consent from consumer representative, risk assessment and behaviour support plans were completed within last three months. For consumers requiring environmental and mechanical restraint, restraint authorisations, risk assessments, monitoring and behaviour support care plans were noted to be current. A member of the clinical management team oversees the restrictive practice portfolio to ensure risk assessments, consents, authorisations and care plans are current.

Based on the information detailed above, it is my decision this Requirement is now Compliant.

# STANDARD 4 Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team did not assess all Requirements in this Standard therefore an overall summary or compliance rating is not provided.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

Most consumers expressed satisfaction with meals provided by the service, including the quality and quantity of meals. Meals provided to consumers were varied, of suitable quality and quantity, and the menus were designed in consideration of consumer and representative feedback and consumer dietary needs and preferences.

Feedback from consumers during the Assessment contact visits was mixed, including some negative feedback in relation to the temperature of meals. Following feedback provided to management regarding the temperature of meals, the service committed to extra temperature checking of meals including the last meal served. The service will also consider the purchasing of heated trolleys to transport meals to consumers. This was further evidenced by meeting minutes submitted by the Approved provider whereby meal temperatures were discussed at a consumer meeting 05 May 2022.

Care documentation for consumers reflected their individual dietary needs and preferences, and this information aligned with feedback provided by consumers and representatives. Nutrition and hydration assessments are completed on entry to the service and dietary requirements for new consumers are communicated to hospitality and catering staff. Consumer dietary profiles are updated when changes occur and include diet types, food consistencies, allergies, likes and dislikes and dietary supplementation. Each of the kitchenettes at the service had a Dietary Requirements and Drinks Preferences folder which contained each consumers’ dietary profile. This folder was updated weekly and as changes are made. Review of this document evidenced it was up to date with current information.

The Head cook, and care staff explained the specific dietary needs and preferences of the sampled consumers and had a shared understanding of the process for monitoring the dietary requirements within the kitchen and kitchenettes. Care and kitchen staff confirmed they are alerted to a change in a dietary summary sheet as any changes are highlighted for their attention. The menu was seasonal and designed in consultation with the consumer cohort and dietitians. Supplementary menus were available for consumers with specific dietary needs, including diabetic and lactose free options.

The service monitored consumers’ enjoyment of the meals and whether the quantity of food available to consumers is adequate. These monitoring processes include informal feedback received from consumers and representatives and staff after each meal service, feedback and complaint processes, and through consumer surveys. Review of the Consumer Experience survey dated January 2022 evidenced that the overall satisfaction with meals was 80%. Management stated any identified trends or complaints regarding meals were actioned through their Action Plan for Continuous Improvement.

The kitchen was observed to be clean and tidy, and kitchen staff were adhering to food and work, health and safety protocols. These protocols include temperature monitoring of refrigerators and meals, ensuring that food products were stored correctly, and following the service’s cleaning schedule. Care staff were assisting consumers with their meals when required and offering them choices of meals and beverages during meal services. The menu was displayed in the dining areas throughout the service.

Actions have been taken in relation to the Non-compliance in this Requirement at the site audit conducted 18-20 October 2021. The service evidenced consultation had taken place between the Catering Manager and consumers who wished to discuss their meal preferences and choices. This consultation occurred during the months of November 2021 and continued to April 2022. The Service conducted monthly satisfaction surveys with consumers. This information was then bench marked with national standards to ensure the service was meeting the needs of the consumers.

Staff received training in the services electronic management system to access dietary needs and preferences for consumers. Care and catering staff confirmed they had access to both electronic and paper-based information pertaining to consumers’ dietary meals and preferences. A third-party food safety audit was conducted in November 2021 and the service was found compliant with the current food safety program Queensland.

Based on the information detailed above, it is my decision this Requirement is now Compliant

# STANDARD 8 Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Assessment Team did not assess all Requirements in this Standard therefore an overall summary or compliance rating is not provided.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(e) Compliant

*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.*

The organisation had a documented clinical governance framework that incorporates its information management system. The organisation provided assistance through their senior management team of the organisation to the staff that engage with consumers, namely the Service Manager, clinical management, care, and services staff that deliver care and services.

The organisation’s governance framework operated in union with policies relating to antimicrobial stewardship, minimising the use of restrictive practices and open disclosure. Management and staff were trained in these policies and understood how to apply the policies to their work.

When managing complaints or incidents, the principles of open disclosure were applied so consumers and representatives were fully informed and provided with an apology. Monitoring actions were incorporated into the organisation’s clinical information system to identify consumers that were receiving psychotropic medication or who are chemically restrained. A restrictive practices policy and procedure was developed, and education was provided to all staff. Antibiotic usage and resistance data were reviewed through the service’s infection surveillance program, and the service subscribed to the National Antimicrobial Prescribing Survey which assessed their antimicrobial prescribing practice and monitored their infections.

Actions have been taken in relation to the Non-compliance in this Requirement at the site audit conducted 18-20 October 2021. The service completed risk assessments for all consumers who had restrictive practices in place. Registered staff had a shared understanding of the requirement to complete a risk assessment for consumers who were prescribed psychotropic medication as a chemical restraint or who were environmentally or mechanically restrained. Registered staff confirmed they received training and education around restrictive practices and the assessment of consumers prior to the implementation of restrictive practices. Review of the service’s Psychotropic medication register evidenced all consumers were assessed prior to commencement of the medication or when reviews occurred. Review of restrictive practice documentation evidenced regular review in line with the service’s review policy.

The service collected clinical indicator data each month through their monthly clinical indicator report that was reviewed, trended and actioned. The organisation and hence the service was benchmarking their results through The National Aged Care Quality Indicator programme. This information was then used to guide care practice. The service evidenced that clinical governance at the service level is managed by the Service manager, Clinical care coordinators, Quality coordinator and all Registered nurses. Monthly Clinical Governance meetings were held with the organisation’s Head Office in Melbourne. At this meeting all clinical risk was discussed, reviewed and trended to identify areas of improvement and attention. Information arising from this meeting was then passed down to staff at the service through weekly Clinical catch up meetings and daily huddle meetings with care staff.

Based on the information detailed above, it is my decision this Requirement is now Compliant.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.