Performance

Report

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| Name of service: | Oaklea Hall |
| Service address: | 4-8 Earlstown Road HUGHESDALE VIC 3166 |
| Commission ID: | 3213 |
| Approved provider: | Aged Care Group Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 10 August 2023 |
| Performance report date: | 19 September 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 Oaklea Hall (**the service**) has been prepared by N Eastwood, 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 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)(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

The service was previously found non-compliant with this requirement following a Site Audit performed between 2 May and 4 May 2022 (the Site Audit). At the time of the Site Audit the service did not demonstrate it had processes and practices to ensure effective and timely review of assessment and care planning, specifically in relation to residents who experienced falls.

The service has implemented several effective actions in response to the identified non-compliance including broader oversight of assessment, planning and evaluation particularly related to falls, updates to the Registered Nurse induction program to ensure introduction to the care plan process and incident management protocol and implementation of an electronic care planning system.

Consumers, representatives, and staff described the regular review of care plans and discussion when changes to consumer care needs occur. Care plan documentation and incident reports reflected falls were investigated, care needs reassessed for the effectiveness of care and evaluation of falls prevention strategies by a physiotherapist and/or medical officer. Staff explained the individualised strategies in place to assist consumers and how they communicate with representatives when changes occur and at the time of review.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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 |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 2 May and 4 May 2022 (the Site Audit). At the time of the Site Audit the service did not demonstrate it had processes and practices to ensure consumers were receiving best practice and optimal care in relation to restrictive practices specifically in relation to environmental restraint and behaviour support planning for consumers subject to chemical restraint.

The service has implemented several effective actions in response to the identified non-compliance including 3 monthly review of restrictive practice consents and care plans, behaviour support plans have been reviewed and updated, there are monthly reporting mechanisms and staff training has been delivered in addition to mandatory training requirements.

Consumers and representatives confirmed they have provided consent for the use of restrictive practice. Staff described individualised strategies are utilised to ensure chemical restraints are used as a last resort. All reviewed care files demonstrate each consumer subject to restrictive practices has a behaviour support plan in place which includes personalised interventions and reflect geriatrician or treating medical officer review. Training records reflect the delivery of multiple education sessions related to behaviour management, restrictive practices, and dementia.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 2 May and 4 May 2022 (the Site Audit). At the time of the Site Audit the service did not demonstrate that complaints and feedback were captured in the service’s complaints register.

The service has implemented several effective actions in response to the identified non-compliance including a retrospective review of the complaints register, addition of actions to the Plan for Continuous Improvement related to education around infection control practices, communication with families regarding planned activities and management newsletter, adoption of an open-door policy to encourage consumers, relatives and staff to provide feedback, additional electronic resources to facilitate live feedback to be sent to managers.

Consumers and representatives described how they can provide feedback by using the ‘opportunity to improve’ form and at resident meetings. Management explained they review feedback regularly and carry out care file reviews and documented complaints as well as verbal feedback. Staff have received training in the customer complaints and feedback procedure, and in the open disclosure process and report feedback and complaints to their manager, at meetings and by using the ‘opportunity to improve’ forms. The complaints register confirmed examples of feedback from consumers being implemented.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 2 May and 4 May 2022 (the Site Audit). At the time of the Site Audit the service did not demonstrate that staff training was in place for antimicrobial stewardship, open disclosure, and restrictive practices.

The service has implemented several effective actions in response to the identified non-compliance including addition of antimicrobial stewardship, open disclosure, and restrictive practices as standing staff meeting agenda items, a new electronic online training system to assist with monitoring and reporting compliance with staff training requirements.

Management confirmed there is a training and development procedure’, to guide staff training as well as online learning systems, face-to-face training, external training opportunities and Toolbox/Leaflet sessions. Mandatory training is delivered through the online education platform with monthly monitoring and discussion with staff at the time of performance reviews. Training records confirmed staff had completed training on wound management, medication competency, donning and doffing, the Aged Care Quality Standards, restrictive practice, Serious Incident Response Scheme, incident management, complaint handling, infection control, antimicrobial stewardship, and open disclosure.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# 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. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 2 May and 4 May 2022 (the Site Audit). At the time of the Site Audit the service did not demonstrate effective processes and practices for continuous improvement, regulatory compliance, feedback, and complaints management. Internal audit results were not recorded or linked to continuous improvement activities, call bell response times were not monitored for improvement, staff training did not include antimicrobial stewardship, restrictive practices and open disclosure training and behaviour support plans were not personalised in line with the legislative requirements.

The service has implemented several effective actions in response to the identified non-compliance including policies and procedures that demonstrated appropriate governance systems are in place to inform continuous improvement. Feedback and complaints are now captured in the complaints register, staff training related to related to antimicrobial stewardship, restrictive practices and open disclosure has been completed, analysis of call bell response times is discussed and monitored, and an annual internal audit calendar has been created with audit results, actions and follow up discussed in monthly staff meetings.

Consumers and representatives confirmed they receive updates regarding consumer care and services and can provide feedback and complaints. Staff described open disclosure, feedback and complaints management processes and confirmed regular training was conducted. Continuous improvement actions were discussed, and senior management and the governing body (Board) have information, data, and options to make informed decisions. Continuous improvement actions are discussed in staff, management, clinical and board meetings and at the organisation’s clinical governance meetings.

There was evidence continuous improvement actions were discussed, and senior management and the board have information, data, and options to make informed decisions. Management said staff are informed about new regulatory requirements in staff meetings and via emails and clinical and care staff said they are informed about changes to legislation and regulations in the staff meetings.

The service demonstrated improvement in the identification and effective management of restrictive practices, restrictive practices training. Behaviour support plans were in line with legislative requirements and supporting assessment and supported decision-making forms were completed and signed for environmental, chemical, and mechanical restrictive practices for a sampled consumer.

There is an effective and established complaints management system with governance oversight including documenting, monitoring, responding, and reporting feedback and complaints.

As a result, and with consideration to the implemented actions and available information I find this requirement is now 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)