Performance

Report

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| Name: | Para Hills Residential Care |
| Commission ID: | 6962 |
| Address: | 50 Kesters Road, PARA HILLS WEST, South Australia, 5096 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 28 August 2024 |
| Performance report date: | 18 September 2024 |
| Service included in this assessment: | Provider: 1154 L P Rositano & M Rositano & R M Rositano and S P Rositano  Service: 4370 Para Hills Residential Care |

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 Para Hills Residential Care (**the service**) has been prepared by M Dubovinsky, 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, which 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 report received 13 August 2024 which acknowledged the Assessment Team’s findings and included a range of supporting documents; and
* the performance report for the assessment contact undertaken from 22 November 2023 to 24 November 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Fully Assessed |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **Not Fully Assessed** |
| **Standard 8** Organisational governance | **Not Fully Assessed** |

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.

**Standard 3 requirement (3)(b)**

* Ensure staff have the skills and knowledge to manage high impact or high prevalence risks, including diabetes.
* Ensure policies and procedures support the management of high impact or high prevalence risks, including diabetes.
* Monitor staff compliance with the service’s policies and procedures in relation to management of high impact or high prevalence risks.

# 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)(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

**Requirements (3)(a) and (3)(e)** were found non-compliant following an assessment contact undertaken in November 2023 as assessment and planning processes were not consistently undertaken to enable risks relating to restrictive practices to be identified and appropriate management strategies implemented; and care and services were not regularly reviewed for effectiveness in response to changes in consumers’ care and service needs and incidents. In response to the non-compliance, the provider has implemented a range of improvements, including, but not limited to, a new admission checklist; regular progress note reviews; reviewed the annual audit schedule; reviewed medication, pain and behaviour support plan audits; education to clinical staff regarding ongoing assessment and planning; updated the electronic documentation system; commenced high risk meetings; daily checks of incidents; a handover folder to ensure all staff receive current information; and education to clinical staff regarding ongoing assessment and planning.

At the assessment contact in August 2024, consumers and representatives expressed satisfaction with assessment and planning processes, demonstrating awareness of strategies implemented when risks were identified. Care documentation showed risk assessments were conducted using validated tools and risk mitigating strategies were implemented and documented with ongoing monitoring conducted. Staff were knowledgeable of assessment and care planning procedures and described processes to identify individual risks to consumers’ health and wellbeing.

Consumers and representatives were satisfied care and services were regularly reviewed for effectiveness and felt confident in the competency of staff. Care documentation showed care plans and assessments were regularly reviewed for effectiveness and when circumstances changed or following incidents. Staff said consumers’ care and service plans were reviewed when a consumer’s situation or condition changed or when an incident occurred. The service has policies and procedures to support assessment, care planning and review processes.

Based on the information summarised above I find requirements (3)(a) and (3)(e) compliant in Standard 2 Ongoing assessment and planning with consumers.

# 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. | Not Compliant |

Findings

The Quality Standard is non-compliant as requirement (3)(b) is non-compliant.

**Requirement (3)(a)** was found non-compliant following an assessment contact undertaken in November 2023 as each consumer was not receiving safe and effective clinical care that was best practice, tailored and optimised their health and wellbeing, specifically in relation to behaviour support, administration of psychotropic medications, and monitoring of fluid input/output. In response to the non-compliance, the provider implemented a range of improvements, including, but not limited to, a range of clinical audits; purchased additional pressure relieving devices; and reviewed medication management processes.

At the assessment contact in August 2024, consumers and representatives said they were happy with the care and services consumers received, and staff knew them and what assistance they needed. Staff interviewed gave examples of how they ensured care and services are delivered in a safe and effective manner and how care and services are tailored for each consumer. Documentation viewed showed changed behaviours, pain, falls, weight and skin was being effectively managed. The organisation has policies and procedures to guide staff to ensure best practice is achieved and care and services provided optimise consumers’ health and wellbeing.

Based on the information summarised above, I find requirement (3)(a) compliant.

**Requirement (3)(b)** was found non-compliant following an assessment contact undertaken in November 2023 as high impact or high prevalence risks relating to diabetes and time sensitive medications were not effectively managed. In response to the non-compliance, the provider has implemented a range of improvements, including, but not limited to, education for staff in relation to falls, restrictive practices, and behaviour support; and progress note reviews to ensure clinical staff follow consumers’ diabetic management plans when blood glucose levels (BGL) are outside reportable range.

However, at the assessment contact, the Assessment Team recommended the requirement not met as effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to diabetic management was not demonstrated. Although clinical staff demonstrated an understanding of diabetic monitoring, including BGLs and administration of as required medication, documentation for two consumers did not demonstrate their medication was administered in line with medical officer’s directives. The following evidence was considered relevant to my finding;

* One consumer, on 3 occasions in a one-month period, was not administered their medication to manage their diabetes consistent with the medical officer’s directive. In addition, documentation informs staff to contact the medical officer when the BGL reading is above a certain level and to undertake an additional BGL reading an hour later, however, documentation did not demonstrate this to be occurring consistently.
* One consumer, on 2 occasions in a one-month period, was not administered their medication to manage their diabetes consistent with the medical officer’s directive.
* Management confirmed they have been working with clinical staff to ensure consumers’ diabetes is effectively managed, with BGLs and insulin completed in line with medical officer’s directives and staff undertake regular audits.
* Management stated staff have been informed to capture all consumers’ BGLs on both the documentation system and in the medication system, however, documentation for both consumers showed staff were not consistently recording BGLs in both systems.

The provider’s response indicates they agree with the Assessment Team’s report and are committed to resolving the deficits identified. The response included meeting minutes discussing diabetes management; a weekly falls reports; an audit report for all consumers who require insulin and diabetes monitoring and management; a blank spot training report; high risk meeting log listing consumers requiring diabetes management; a high impact and high prevalence risk meeting document outlining a range of risk types, including diabetes; and meeting minutes showing risks are being recorded on a log.

Based on the Assessment Team’s report and provider’s response, I find high impact or high prevalence risks relating to diabetes were not effectively managed. For 2 consumers, staff did not consistently follow the medical officer’s directive and administer the relevant as required medication to manage the high impact risks associated with diabetes, did not consistently record BGLs to support optimal monitoring consistent with internal processes and did not consistently contact the medical officer when a consumer’s BGL was outside of their specified range. In coming to my finding, I have also considered the potential adverse impact to consumers resulting from not having their diabetes effectively managed, specifically in the context of the medications being used. While a range of documents were included in the provider’s response, such as planned training, copies of audits and meeting minutes, I have considered time will be required to implement and embed effective processes to ensure improvements are sustained and monitored for effectiveness.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

**Requirement (3)(c)** was found non-compliant following an assessment contact undertaken in November 2023 as the workforce was not sufficiently competent or had the knowledge to effectively perform their roles to ensure effective assessment, planning and review or to support the delivery of safe and effective clinical care. In response to the non-compliance, the provider has implemented a range of improvements, including, but not limited to, training for clinical staff on management of pain, medications and hydration; and increased monitoring of staff practice.

At the assessment contact in August 2024, consumers said they have no concerns about staff competency and were satisfied with how staff have managed their pain, wounds, falls and changed behaviours. Staff described receiving guidance from management to ensure they have the knowledge to deliver safe and effective care and services. Management described their processes to ensure staff maintain current and relevant knowledge to undertake their roles in a professional manner, and a commitment to ongoing professional development. The organisation has processes to ensure staff and others have the qualifications and knowledge to effectively perform their roles.

Based on the information summarised above I find requirement (3)(c) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

**Requirement (3)(d)** was found non-compliant following an assessment contact undertaken in November 2023 as risk management systems and practices relating to managing high impact or high prevalence risks and incident management were not effectively applied. In response to the non-compliance, the provider has implemented a range of improvements, including, but not limited to, increased toolboxes and ongoing staff training on incident reporting and risk assessment and management; audits to ensure incidents are appropriately managed; bi-monthly clinical governance committee meetings to monitor clinical care and data; monthly risk management meetings; and reviewed the annual audit schedule to ensure clinical deficits identified have been addressed.

At the assessment contact, the organisation demonstrated effective risk management systems, and practices. Consumers are encouraged to take risks, and consumers stated risks are discussed with them and strategies implemented to support them in taking risks which enable them to live the best life they can. Incidents of abuse and neglect are managed and documented through the service’s incident management system. A high risk and high prevalence register identifies risks, such as complex wounds, weight loss, medication management, infections and psychotropic medication. The organisation has an incident management policy and procedure, and an incident management system to support the analyses and investigation of incidents. Bi-monthly clinical governance committee meetings and monthly risk management meetings ensure risks are effectively managed and include a review of clinical indicators, clinical risks and staff training needs, and the risk register is regularly discussed.

Based on the information summarised above I find requirement (3)(d) in Standard 8 Organisational governance 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)