Performance

Report

**1800 951 822**

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| Name of service: | Peter Cosgrove House |
| Service address: | 90 Veterans Parade NARRABEEN NSW 2101 |
| Commission ID: | 2326 |
| Approved provider: | RSL LifeCare Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 November 2022 to 23 November 2022 |
| Performance report date: | 23 December 2022 |

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 Peter Cosgrove House (**the service**) has been prepared by T 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 - 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 team’s report received 13 December 2022.
* the Performance Report dated 21 January 2022 following the Site Audit undertaken from 14 December 2021 to 17 December 2021, where fourteen Requirements were found to be Non-compliant.

# 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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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 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

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 3(3)(a)

* ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical that is best practice, specifically in relation to diabetic management and restrictive practices.

# 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)(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 |

Findings

Requirement 2(3)(a) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate assessment and planning, including consideration of risks to the consumer’s health and wellbeing, informed delivery of safe and effective care and services.

During the assessment contact undertaken between 22 November 2022 to 23 November 2022, The Assessment Team found that the service demonstrated they undertake assessments when consumers first enter the service and there is a consistent process to capture all relevant information that ensures safe and effective care and services delivery.

Care planning documentation demonstrates assessment and planning is occurring for consumers, including assessing risks to the consumer's health and well-being. One care manager stated all new consumers entering the service are assessed for risks and risk mitigation strategies are put in place. Review of care planning documentation confirmed this.

Based on the information provided by the Assessment Team, I find Requirement 2(3)(a) Compliant.

Requirement 2(3)(b) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate that initial assessments were completed for consumers in accordance with the service’s initial assessment and care planning procedures. The service was also unable to demonstrate that consumers’ care plans included all information about their current needs, goals, and preferences, or if documented were not followed by staff.

During the assessment contact undertaken between 22 November 2022 to 23 November 2022, review of consumers’ assessment and planning documentation demonstrated consumer care plans are reflective of their current needs, goals, and preferences, including advance care planning and end of life planning.

Staff could describe what is important to the consumer in terms of how their care is delivered. Management advised end of life care planning discussions are offered to consumers and/or representatives on entry to the service or when the consumer’s condition changes.

Based on the information provided by the Assessment Team, I find Requirement 2(3)(b) 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement 3(3)(a) is non-compliant.

Requirement 3(3)(a) was found non-compliant following a previous assessment of the service. The service did not demonstrate consumers’ personal and clinical care had been tailored to their needs and optimised their health and well-being. The Assessment Team identified deficits in pain management, wound management, and medication management.

During the assessment contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team identified not all consumers were receiving best practice clinical care that is being tailored to their needs and is not optimising their health and well-being. This includes diabetic management, management of an enteral feeding device, neurological observations, and restrictive practices.

The Approved Provider responded with a detailed plan for continuous improvement to address the identified deficits. I acknowledge the Approved Provider have already addressed and clarified some of the identified deficits, however due to the nature of the deficits being systems based I feel that the Approved Provider will require time to embed the practices in their daily routine.

Based on the information provided by the Assessment Team, I find Requirement 3(3)(a) Non-compliant.

Requirement 3(3)(b) was found non-compliant following a previous assessment of the service. The Assessment Team identified deficits in the management of high impact and high prevalence risks associated with the care of residents.

During the assessment contact undertaken between 22 November 222 to 23 November 2022, the service demonstrated effective processes to manage high impact or high prevalence risks associated with the care of each consumer. Care planning documentation generally identify effective management of high impact high prevalence risks, including falls, wound and behaviour management.

Based on the information provided by the Assessment Team, I find Requirement 3(3)(b) Compliant.

Requirement 3(3)(g) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate effective management of standard and transmission-based precautions to prevent and control infections.

At the assessment contact undertaken on 22 November 2022 to 23 November 2022, the service was able to demonstrate its preparedness and activation of their COVID-19 outbreak management plan. The service demonstrated careful and responsible management of medications, activities which promote and support best practice, and how the service minimises infection related risks with standard and transmission-based precautions.

Based on the information provided by the Assessment Team, I find Requirement 3(3)(g) 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 |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement 4(3)(a) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate that each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimised their independence, health, well-being, and quality of life.

During the assessment contact undertaken between 22 November 222 to 23 November 2022, consumers and/or representatives felt there are a variety of activities offered at the service to meet their needs. It was also demonstrated that there are sufficient activities for those consumers who are wheelchair bound and in need of one-to-one engagement.

Consumers and/or representatives stated there are enough staff to conduct activities of interest for them throughout the week. Documentation supports staff are assessing and identifying consumers’ needs, goals and preferences and optimising their health and well-being.

During the assessment contact, most consumers and/or representative feedback indicated significant concerns in relation to the quality of the laundry service.

The feedback included; white clothing turning grey, clothes stained, towels stained, clothes damaged, clothes returned so crinkled they could not be worn, clothing shrunk, wrong clothes delivered to consumers’ rooms and multiple items of consumer’s clothing is being lost.

The Assessment Team advised management of the consumer feedback related to the laundry during the assessment contact. It was clarified that the service was experiencing issues with lost clothing due to a faulty labelling machine causing labels to fall off during washing. A new labelling machine had since been purchased and delivered.

The management team reported they had not been aware of consumer and/or representative concerns related to the laundry system.

The Approved Provider responded with a detailed plan for continuous improvement, including but not limited to commencement of fortnightly laundry focus group meetings, staff huddles to include feedback related to laundry services, all identified concerns followed up and documented, education to staff on identifying feedback and complaints, representatives were provided with education regarding feedback and complaints related to laundry.

Based on the information provided by the Assessment Team, as well as the information provided by the Approved Provider I find Requirement 4(3)(a) Compliant.

Requirement 4(3)(f) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate where meals were provided, they were varied and of suitable quality and quantity. In particular it was identified by some consumers that the meals served were not always hot, they were not always getting the meals they requested, food was bland and of average quality and the meat was tough and chewy.

At the assessment contact undertaken on 22 November 2022 to 23 November 2022, consumers and/or representatives advised the food is very good. They stated they get plenty to eat and have plenty of choice for each meal.

Consumers and/or representatives advised there is a variety of snacks available outside of mealtimes. One consumer reported if they do not like what is on the menu the kitchen will provide them with an alternative option. Documentation reviewed identified individual consumer dietary needs and preferences are aligned with consumer feedback.

Based on the information provided by the Assessment Team, I find Requirement 4(3)(f) Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement 6(3)(b) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate how consumers were made aware of and had access to advocates, language services and other methods for raising and resolving complaints.

In particular, it was identified consumers were not familiar with advocacy services and stated they did not know how to make a complaint unless it was made to staff members or the management team.

At the assessment contact conducted on 22 November 2022 to 23 November 2022, consumers and/or representatives advised they are aware of and have access to advocates, language services and other methods for raising and resolving complaints.

Based on the information provided by the Assessment Team, I find Requirement 6(3)(b) Compliant.

Requirement 6(3)(c) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate how appropriate action was taken in response to complaints and an open disclosure process was used when things go wrong. In particular, consumers and/or representatives identified complaints were not always actioned and resolved to their satisfaction.

At the assessment contact undertaken on 22 November 2022 to 23 November 2022, consumers and/or representatives confirmed appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

Based on the information provided by the Assessment Team, I find Requirement 6(3)(c) Compliant.

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed, enabled the delivery and management of safe and quality care and services.

Specifically, there were not enough staff to meet the consumers’ needs in a timely manner, with consumers waiting extended periods for call bells to be answered which had negative impacts on consumers.

At the assessment contact conducted on 22 November 2022 to 23 November 2022, the service was able to demonstrate that they have recruited a number of additional staff members to help cover the shortfalls in the roster.

The service has employed a clinical nurse education who is employed full time and works across both Peter Cosgrove House and Phyllis Steward House. Feedback received from consumers and/or representatives was mainly positive in relation to the workforce.

Based on the information provided by the Assessment Team, I find Requirement 7(3)(a) Compliant.

Requirement 7(3)(d) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate the workforce was recruited, trained, equipped, and supported to deliver the outcomes required by the Quality Standards specifically in relation to not having scheduled training for its staff.

At the assessment contact undertaken on 22 November 2022 to 23 November 2022, the service was able to demonstrate that they implemented several actions to address the identified deficits.

The service conducted a gap analysis and created and education calendar, as well as employed a clinical nurse educator to address identified staff knowledge gaps.

The service was given a list of education topics that needed to be covered by the organisation’s learning and development team. These topics include mandatory education face to face and online as well as other education topics as determined by the learning and development team.

Based on the information provided by the Assessment Team, I find Requirement 7(3)(d) Compliant.

Requirement 7(3)(e) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce was undertaken, specifically in relation to not conducting performance reviews and appraisals in a regular manner.

At the assessment contact conducted on 22 November 2022 to 23 November 2022, the service was able to demonstrate several actions implements to address the identified deficits. The service implemented a system to ensure staff reviews occur annually on the employee anniversary dates.

Based on the information provided by the Assessment Team, I find Requirement 7(3)(e) Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| 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

Requirement 8(3)(a) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate how it engaged consumers in the development, delivery and evaluation of care and services.

During the assessment contact between 22 November 2022 to 23 November 2022, the service demonstrated how consumers are involved in the development, delivery and evaluation of their care and services.

Consumers and/or representatives interviewed stated they felt the service was well run. The service has effective systems in place to monitor and action consumer feedback on aspects of care and services delivery.

The service demonstrated regular consumer meetings occur, which are well attended and capture the consumer voice. Feedback and complaints processes are in place which enables consumers and/or representatives to provide feedback and input.

Consumer surveys are conducted regularly and are tailored to reflect an identified area of care and services where consumer input is sought, such as food and meals.

Several focus groups are held to discuss and plan what is important to consumers, including a food focus group where menus are developed and reviewed to reflect consumers’ choice and preferences, and a lifestyle focus group which plans and evaluates the lifestyle program and activities.

Based on the information provided by the Assessment Team, I find Requirement 8(3)(a) Compliant.

Requirement 8(3)(c) was found non-compliant following a previous assessment of the service. The service was unable to demonstrate effective organisation wide governance systems in relation to feedback and complaints, and regulatory compliance in relation to the implementation of the service’s restraint policy for some consumers.

At the assessment contact conducted on 22 November 2022 to 23 November 2022, the Assessment Team reviewed evidence to support that the service has improved its feedback and complaints system, consumers and/or representatives felt they could provide feedback and knew how to do so. In relation to regulatory compliance and the implementation of the service’s restrictive practices policies, the service was able to demonstrate it has made significant improvements in managing authorizations and psychotropic medications.

The Assessment Team reviewed the organisation’s governance systems and identified new issues in relation to its information management and continuous improvement governance systems.

The service has information management systems including electronic care planning, risk management, compliance, education/training and human resources. Reports and data are generated from these systems for analysis and review by staff. Management advised relevant information, including areas of risk to consumers, is escalated to the board. However, it was noted there were some gaps in the service’s information systems which impedes easy access to consolidated service information for management oversight.

The Plan for Continuous Improvement was provided as two different plans, with no consolidated service information on the areas for improvement for overall management analysis, monitoring and review for the service.

The Approved Provider responded with a detailed plan for continuous improvement, including but not limited to transitioning all facilities to using a single document format for their plan for continuous improvement, introduction of a single education calendar for both Peter Cosgrove House and Phyllis Steward House, monthly facility consolidation meetings to enable consolidation, monitoring and analysis of items.

Based on the information provided by the Assessment Team, as well as the information provided by the Approved Provider I find Requirement 8(3)(a) 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)