

**Performance Report**

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| Name: | Pines Living |
| Commission ID: | 2950 |
| Address: | 272 Beasley Street, FARRER, Australian Capital Territory, 2607 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 12 November 2024 |
| Performance report date: | 13 December 2024 |
| Service included in this assessment: | Provider: 2875 Pines Living Pty Ltd  Service: 6571 Pines Living |

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 Pines Living (**the service**) has been prepared by L Glass, 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, older people/representatives and others
* the provider’s response to the assessment team’s report 9 December 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all Requirements were assessed** |
| **Standard 7** Human resources | **Not applicable as not all Requirements were 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

* In relation to Requirement 2(3)(a) undertake the comprehensive assessment processes following the organisation’s procedures for reviewing, assessing and planning for consumer and use the assessments to inform consideration of risks to the consumer’s health and well-being, and the delivery of safe and effective care and services
* In relation to Requirement 3(3)(b) investigate and manage high impact and high prevalence risks and incidents associated with consumer’s pain, medication, falls and skin integrity management
* In relation to Requirement 3(3)(d) implement effective and/or timely manner escalation and responses to consumer deterioration.

# 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. | Not Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |

Findings

In relation to Requirement 2(3)(a) the Assessment Team found while the service has systems in place to identify care and service needs for consumers at admission, it did not demonstrate it effectively considers risks to the consumers’ health and well-being to inform the delivery of safe and effective care and services. Overall, consumers and representatives gave positive feedback about their assessment and care planning. Care staff are familiar with the risks to sampled consumers’ health acuity. However, while documentation reviewed indicated some consumer risks are included in care and service plans, not all risks are included. For some consumers in sample reviews risks were not always documented in the risk domain of the care and service plans to provide staff with appropriate information and guidance in delivery of care and service.

Staff described the risks and strategies to support each consumer relevant to the identified risk. Assessments are conducted during the first 21 days after a consumer enters the service and the assessments inform the care and services plan.

Review of initial care and services plans for 4 additional consumers showed the service does undertake a suite of assessments to identify needs, preferences and risks for consumers entering the service. However, risks are not adequately recorded nor are they managed to ensure the mitigation of the risks to support consumers’ choice. Several examples were provided. The Assessment Team recommended Requirement 2(3)(a) is Not Met.

The Approved Provider supplied a written response (the response) to the Assessment Team report. In the response the Approved Provider agreed with the assessment findings acknowledging that the service has systems in place but that it had not consistently demonstrated that the risk of consumers informed the delivery of safe and effective care. The response included a plan for continuous improvement outlining improvements and actions required, progress towards outcomes and evaluation. Detailed information about identified consumers, current assessments and reviews were also provided documenting the actions taken and planned since the assessment activity, specific to each consumer’s specific risk. A clinical risk management auditing will be used to conduct routine assessments for all consumers on entry to the service and quarterly thereafter. Management plans to ensure all associated documentation is completed.

In making my decision I have considered the Assessment Team report and the response from the Approved Provider. I acknowledge the progress made in improving the identification, documenting and managing of risks for consumers and the plans for regular reassessment. However, as the strengthened processes and initiatives for assessment have just commenced, I consider the service is yet to demonstrate consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. I find Requirement 2(3)(a) Not Compliant.

In relation to Requirement 2(3)(c) the service demonstrated the review of care and services occurs in partnership with the consumer and their representative. Consumers inform staff about who they want to have involved in their care and this is documented in the consumer file. Staff know the family members and friends involved in the consumers’ care and services. Review of some consumers’ care files indicated those to be included in the consumer’s care and services are documented including other organisations and practitioners involved such as a medical officer, physiotherapist, speech pathologist, dietitian, podiatrist, and allied services are providers of care and services to consumers at the service. Review of documentation shows regular case conferences with the consumer and representative are undertaken. The Assessment Team observed a podiatrist and medical officer providing consultation to consumers during the Assessment Contact. The Assessment Team recommended Requirement 2(3)(c) is Met. I accept the Assessment Team’s recommendation. I find Requirement 2(3)(c) Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |

Findings

In relation to Requirement 3(3)(b) the Assessment Team found while the service has systems in place to identify high-impact or high-prevalence risks to consumer care the service did not demonstrate consumers with high-impact and high prevalence risks were managed effectively in relation to pain management, medication management, falls management, skin integrity and pressure injury prevention. Overall, the evidence shows high-impact and high-prevalence risks associated with the care of consumers are not being effectively managed. The Assessment Team recommended Requirement 3(3)(b) is Not Met.

The Assessment Team found pain management is not always adequately documented or managed in consideration of the risks to the consumers’ overall health and well-being. Review of consumers’ pain management indicates pain management is not always in accordance with best practice or aligned to the organisation’s expectations in relation to risk mitigation and support.

A review of the documentation and interviews with consumers showed that repositioning is not consistently occurring or reflecting documented directions for pressure injuries. The incident register recorded a significant number of entries related to skin integrity, most of which were due to Incontinence Associated Dermatitis (IAD) and pressure injuries indicating the service is not managing skin integrity effectively.

A review of the documentation and interviews with consumers revealed the service is not effectively managing medication administration for consumers. Medication charts showed that time-sensitive medications, were not consistently administered at the scheduled time. Management acknowledged the issue and confirmed they are implementing continuous improvement plan actions focused on medication competency assessments and education for internal staff.

A review of the documentation and interviews with consumers showed the service is not effectively managing falls prevention and risk for consumers with mobility concerns. A care file review revealed that specific falls management strategies were not in place. The Assessment Team recommended Requirement 3(3)(b) is Not Met.

The Approved Provider supplied a written response (the response) to the Assessment Team report. In the response the Approved Provider stated the service agreed with the Assessment Team’s findings and that although the service has systems in place to identify high impact/high prevalent risk it did not demonstrate the risks were managed effectively in relation to pain management, medication management, falls management, skin integrity and pressure injury prevention. A plan for continuous improvement was supplied. Action plans for each of the identified consumers were also supplied in the response with detailed and updated evidence of actions taken and improvements to care and services delivered in particular for falls, medication, pain and skin integrity management. Processes have been put in place to ensure oversight of staff performance including timely completion of documentation. Education for staff about managing skin integrity has also been implemented.

In making my decision I have considered the Assessment Team report and the response from the Approved Provider. I acknowledge the progress made in improving the identification, documenting and managing of high impact/high prevalent risk risks for consumers. I also acknowledge the improvements made in delivering care to identified consumers and the education of staff. However, I consider the service is yet to demonstrate effective management of high-impact or high-prevalence risks to consumers. I find Requirement 3(3)(b) Not Compliant.

In relation to Requirement 3(3)(d) the Assessment Team found the Assessment Team identified the service had not responded to a consumer’s change of physical function in a timely manner. While the staff described processes for the escalation of changes in consumers' conditions, the service did not demonstrate changes in consumer skin integrity or their responsive behaviours were identified, clinically assessed, and escalated. A review of care documents for several consumers who experienced deterioration over a sustained period showed processes for the escalation and response to deterioration have not been implemented effectively or in a timely manner. The Assessment Team recommended Requirement 3(3)(d) is Not Met.

The Approved Provider supplied a written response (the response) to the Assessment Team report. In the response the Approved Provider agreed that resident deterioration and changes in consumers physical functions and conditions are not consistently recognised and responded to in a timely manner. The response detailed reviews of identified consumers, updated documentation and reassessments. Relevant policies were also provided.

In making my decision I have considered the Assessment Team report and the response from the Approved Provider. I acknowledge the revised dignity of risk forms have been updated and/or completed and the inclusion of strategies to minimise risks and identify consumer deterioration in particular for consumers with complex care needs. However, I consider the service is yet to demonstrate it consistently engages in effective implementation of the processes to recognise and respond in a timely manner to consumer deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition. I find Requirement 3(3)(d) Not Compliant.

# Standard 6

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| Feedback and complaints | |  |
| 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

Consumers and representatives confirmed management is responsive to any matters raised. The organisation has policies and procedures for managing feedback and complaints, including for the use of open disclosure principles. Feedback and complaints are recorded along with any action taken in response to the matters raised. Issues are delegated to the appropriate person responsible and reviewed at the weekly leadership team meetings. The process is overseen by the general manager to ensure appropriate action is taken in response to complaints and that a process of open disclosure is used when things go wrong.

The Assessment Team reviewed the complaints register. All complaints and concerns are given a risk rating and logged into the plan for continuous improvement. The complaints register showed complaints and concerns were acknowledged, actioned, documented, and resolved in a timely manner. The Assessment Team recommended Requirement 6(3)(c) is Met. I accept the Assessment Team’s recommendation. I find Requirement 6(3)(c) 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

Consumers and representatives were satisfied staff are meeting the needs of consumers and are trained and competent to deliver the care and services required. There are policies and procedures for managing the workforce, and position descriptions set out the responsibilities and necessary qualifications and skills for each role. The service monitors the qualifications of registered staff and contactors. Management demonstrated staff are competent and have the qualifications and knowledge to effectively perform their roles. The service provides a comprehensive orientation program to ensure new staff have the knowledge and skills to effectively perform their roles. The orientation includes mandatory training, competency assessment, and induction on site. Staff described their roles and the processes they use to effectively perform these roles. Staff confirmed they have participated in training provided at the service. The Assessment Team recommended Requirement 7(3)(c) is Met. I accept the Assessment Team’s recommendation. I find Requirement 7(3)(c) 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)