Performance

Report

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| Name: | Rockpool Carseldine |
| Commission ID: | 5842 |
| Address: | 56 Plaza Place, CARSELDINE, Queensland, 4034 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 23 April 2024 |
| Performance report date: | 27 May 2024 |
| Service included in this assessment: | Provider: 7088 Rockpool RAC Pty Ltd  Service: 27834 Rockpool Carseldine |

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 Rockpool Carseldine (**the service**) has been prepared by E Blance, 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, consumers/representatives and others
* the provider’s response to the Assessment team’s report received 14 May 2024.
* other information known by the Commission.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable as not all Requirements were assessed |
| **Standard 7** Human resources | **Not Applicable as not all Requirements were assessed** |
| **Standard 8** Organisational governance | **Not Applicable as not all Requirements were 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 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. | 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. | Compliant |

Findings

Requirement 3(3)(b)

The Assessment team report brought forward information the service was unable to demonstrate effective processes for identifying medication errors and managing medication incidents for consumers who are prescribed time sensitive medications.

The Assessment team identified 2 consumers where time sensitive medications had not been administered on time and one consumer reported this had caused them to be anxious. Registered staff were aware of the importance of administering time sensitive medications and the process for reporting medication errors as an incident, however the Assessment team found that medication errors had not been recorded within the incident management system for 2 consumers. The Assessment team reported the service were experiencing technical difficulties with the medication administration system.

I have reviewed the information brought forward by the Assessment team as well as the information contained within the provider’s response.

The provider’s response provided information about the governance systems in place for managing time sensitive medications.

The provider’s response acknowledges that incidents were not consistently reported for 2 consumers. The provider has provided evidence to support the following actions have been undertaken to correct the identified deficiency:

* Review of policies and processes.
* Addition of alerts and information against time-sensitive medications.
* Handover sheet amended to include information to prompt registered staff.
* A workflow related to the effective management of time-sensitive medications.
* Staff training.
* Quarterly audits to ensure time-sensitive medications are administered as prescribed.
* Consultation with pharmacists regarding difficulties experienced with the use of the current medication management system.
* Proposal for the implementation of a new medication management system.

Review of the provider’s response as well as the Assessment team report included that the service had identified medication management as an issue at the service and had taken action to mitigate risk to consumers through a number of continuous improvement strategies prior to the assessment contact. I am satisfied the service was aware of the technical issues identified with the use of the current medication management system and that improvements have been actioned and continue to be monitored. While I acknowledge one consumer experienced anxiety in relation to the timely administration of their medication, I am satisfied the provider’s response is appropriate to minimise risk to consumers.

The Assessment team identified the service was able to demonstrate risk and risk mitigation strategies are identified and implemented for consumers at risk of falls and aspiration, however risk mitigation strategies were not documented upon dignity of risk forms. No impact was identified to consumers within the report to support ineffective management of dignity of risk for consumers.

The provider’s response included that strategies for managing dignity of risks identified for consumers are detailed within the relevant care plan, not specifically on the dignity of risk form. Further, the provider has provided supporting evidence to demonstrate dignity of risk governance processes are in place within the service to support consumers. The provider’s response also included evidence to support continuous improvement processes based on the information identified within the report, dignity of risk processes were discussed and reviewed to ensure consistency for the recording of strategies to mitigate risk, they include:

* Discussion related to recording of strategies for mitigating risks identified on a dignity of risk form.
* A new dignity of risk process developed to guide staff.
* Review of the dignity of risk form.
* Training for staff.

I am of the view insufficient evidence was brought forward by the Assessment team to support that the service were not effectively managing consumers at risk of falls and aspiration. No impact was identified for consumers. I consider in response to the information raised within the report, that the provider has proactively undertaken continuous improvement actions to improve dignity of risk processes including that the improvements have been made to dignity of risk forms which will be monitored for their effectiveness.

Prior to the assessment contact the service identified through monitoring processes, that neurological observations were not consistently recorded post fall. The service delivered post falls management training to staff on 10 April 2024.

The Assessment team report brought forward information that neurological observations were not consistently recorded for 2 of 3 consumers who had experienced a fall since 10 April 2024. The Assessment team report discusses consumer documentation, interviews with staff and observations indicate fall prevention strategies identified are implemented and no impact was identified by the Assessment team for the 2 consumers who’s post falls observations were not consistently recorded. No further evidence was provided by the Assessment team.

The provider’s response provided information about the governance systems in place for falls management. The response also included evidence to support that continuous improvement processes based on the information identified within the report have been conducted, they include:

* Review and update of the post-falls management policy.
* Training for staff.
* Implemented audits to ensure post falls management observations are completed.
* General practitioner to review consumers day 3 post fall.
* Monitoring of staff adherence to post falls management procedures.

In addition to the strategies implemented above, the management team advised the Assessment team,registered staff will complete competency assessments in the falls management procedure and be issued with lanyard cards to prompt staff in the post fall management procedure. I note no impact to the 2 consumers was identified and I am satisfied the provider’s response is appropriate to minimise risk to consumers.

Prior to the assessment contact the service identified through monitoring processes, wounds were not consistently measured. Wound care training was provided to staff.

The Assessment team identified wounds for 2 consumers are attended to as per a Nurse practitioner’s recommendations and are monitored by a Nurse practitioner, however reported that wounds were not consistently measured. No impact was identified by the Assessment team to the 2 consumers.

The provider’s response provided information about the governance systems in place for wound management. The service acknowledged that staff did not have a shared understanding for responsibility for wound photography and measurement to support monitoring of wound healing. The response included evidence to support that continuous improvement processes based on the information identified within the report have been conducted, they include:

* Review of wound management policy with advice from the wound specialist.
* Consideration for purchase of equipment to support staff in wound management.
* Training delivered to staff by the wound specialist which includes how to measure wounds.
* Evaluation of training.

While I acknowledge that staff provided inconsistent information regarding the frequency required of measurements for wounds, the wounds were being attended to by the staff in accordance with directives, and the wounds were being monitored by a wound specialist. No deterioration or impact was identified by the Assessment team in relation to the management of the wounds themselves, only the inconsistency of measurements and photographs. I acknowledge a representative expressed they were not confident with the service’s management of wounds for a consumer however, evidence provided by the service demonstrated the wound specialist was conversant of consumer’s wounds and care conferences and information is afforded to consumers and representatives about the management of the wounds. I am satisfied the service proactively responded to the information brought forward within the Assessment team report and the provider’s response is appropriate to minimise risk to consumers.

Based on the information summarised above I am satisfied no impact to consumers was identified by the Assessment team, and the strategies implemented by the provider in response to the report mitigate risk to consumers and are appropriate and proportionate. I find Requirement 3(3)(b) compliant.

Requirement 3(3)(d)

The Assessment team report brought forward information that the service was able to demonstrate effective processes for identifying and responding to a change in a consumer’s condition. Consumers and their representatives said staff can identify a change in consumer’s condition and staff could demonstrate an understanding of the management processes for recognition of deterioration of consumer’s conditions. Care documentation supported a recognised deterioration and timely response including for a consumer who recently experienced a stroke. I find Requirement 3(3)(d) 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 |

Findings

Requirement 7(3)(a)

The Assessment team brought forward information that consumers expressed satisfaction in the service’s ability to meet their care and service needs. Consumers said staff respond quickly to their needs and can meet their preferences for cares. Staff were observed by the Assessment team as responding to consumer requests for care in a timely manner. Staff provided information that the service provides additional staff at peak times to ensure care and services can be delivered. Staff numbers and skill mix are monitored for each area of the service including the memory support unit and adjustments are made where an additional need has been identified. The service has processes to manage both planned and unplanned leave and ongoing recruitment processes to ensure the right number and skill mix of staff. I find Requirement 7(3)(a) 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

Requirement 8(3)(c)

The Assessment team brought forward information that the service has effective organisation-wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, feedback, and complaints.

Information is provided to consumers through meetings. Staff have access to information systems, policies and procedures. Information from feedback, complaints, and incident registers as well as internal audits and staff surveys identify areas for improvement.

The Assessment team brought forward information of gaps identified within incident management systems for 2 consumers, this information was considered in Standard 3.

The service’s plan for continuous improvement (PCI) demonstrated reviews occur and entries are prioritised. The Assessment team brought forward information that continuous improvement opportunities were not identified in relation to gaps identified in Standard 3, however considered that actions taken on past items identified in the PCI gave confidence that newly added items would be actioned accordingly.

The service has effective financial governance in relation to budgets and expenditure.

The service demonstrated effective governance to ensure 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.

The service has governance processes to ensure regulatory compliance including receipt of information through peak bodies, dissemination of information to staff and policies and procedures reflect regulatory changes.

The service has a system in place for the collection, response and analysis of feedback and complaints.

I have reviewed the provider’s response which included information about the governance systems in place regarding the gaps identified in Standard 3. I note the team’s assessment of Requirement 8(3)(c) identifies the service has effective governance systems and based on the information summarised above and consideration to information in Standards 3 and 7, I find Requirement 8(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)