Performance

Report

**1800 951 822**

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| Name of service: | Rosary Home |
| Service address: | 138 Odessa Avenue KEILOR DOWNS VIC 3038 |
| Commission ID: | 3131 |
| Approved provider: | Congregation of Dominican Sisters of Malta (VIC) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 May 2023 to 23 May 2023 |
| Performance report date: | 27 June 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 Rosary Home (**the service**) has been prepared by D.Fekonja, 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 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)(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 |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | 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

The service was found non-compliant with Requirements 2(3)(a) 2(3)(b) 2(3)(d) and 2(3)(e) following a Site Audit from 6 July 2022 to 8 July 2022.

In relation to Requirement 2(3)(a) the service was not able to demonstrate that the assessment and care planning process informs the delivery of safe and effective care and services for each consumer. The service did not consider the risks for the consumers when completing assessments as per the consumers' individual needs, goals, and preferences.

The service has implemented actions to address these deficits which have been effective. These include:

* The service engaged external advisers to assist with the development of new care plans and assessments. These new care plans have been completed in consultation with all consumers and their representatives.
* A new ‘Resident of the Day and three monthly’ process has been established to support the assessments and care planning process to achieve effective care and service delivery. The clinical manager monitors this process and ensures there are no gaps in care plan reviews and the evaluation process.
* Daily 10 am meetings which include a standing agenda that focuses on ‘Resident of Concern’ where the needs, goals, and preferences of the consumers are communicated.
* The service has introduced a ‘dignity and choice form’ that is completed along with risk forms to support resident choices.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023, consumers and representatives expressed satisfaction with the assessment and care planning processes. The Assessment Team found that care plans identify consumers’ current risks to health and well-being and include relevant assessments which inform the delivery of safe and effective care and services. Staff were knowledgeable on risks for consumers and the strategies required to ensure the care provided is safe and effective.

For one consumer with a choking risk, the service ensured referrals to specialists were made and their nutrition and hydration care plans were updated and dietary information was communicated to the catering staff.

In relation to Requirement 2(3)(b) the service was not able to demonstrate that it always identified and addressed consumers’ current needs, goals, and preferences.

The service has implemented actions to address these deficits which have been effective. These include:

* Staff who are able to speak in the same language as the consumer, facilitating the consumers’ interviews to ensure their needs, goals, and preferences are captured and reflected in the care documentation.
* Daily 10 am meetings have been implemented to include a standing agenda that focuses on ‘Resident of Concern’ where the needs, goals, and preferences of the consumers are communicated.
* The service has also reviewed and updated the palliative and end-of-life policy and procedure to guide staff members’ practice and support the consumers’ choice.
* The service has implemented consultation with consumers and representatives about the advanced care plan. All consumers’ advance care plans have been completed and the documents are reviewed with consumers and representatives as part of the three-monthly care plans evaluation process.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023, consumers and representatives said the service is attentive to identifying the consumers’ needs and preferences, informing the delivery of care and services and there is ongoing consultation about the plan of care including advance care directives and end-of-life planning.

In relation to Requirement 2(3)(d) the service was not able to demonstrate that outcomes of assessments and care plans are effectively communicated to consumers and their representatives.

The service has implemented actions to address these deficits which have been effective. These include:

* The policy and procedure named ‘Resident of the Day and Care Plan Evaluation’ has been updated to include the requirement for consumers and representative care consultation.
* The service now offers electronic or hardcopy care plans to the consumers and representatives at the 3-monthly evaluations and if care or services delivery changes occur.
* The clinical manager supervises that care consultations occur and are documented.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023 consumers confirmed they are offered a copy of their care plan at the time of the 3-month evaluation, during the review of care and services, and/or if any change occurs before the scheduled care plan review.

In relation to Requirement 2(3)(e), the service was not able to demonstrate that care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact the needs, goals, or preferences of the consumer.

The service has implemented actions to address these deficits which have been effective. These include:

* The service has reviewed and strengthened its clinical policies and processes.
* The service has implemented a more systematic process for the review of consumer care and directly supervises staff to provide mentoring and direction.
* The service has implemented the ‘resident of the day’ (ROD) process including baseline observations record, weight record, and environmental risk assessment attended by the physiotherapists, which focus on the consumer’s bedroom decluttering, checking appropriate lighting, and furniture disposition.
* The clinical care coordinator (CCC) reviews the care documentation daily. If gaps are identified, the CCC provides direct supervision and mentoring to the clinical staff ensuring these are addressed in a timely manner.
* Implementation of daily mid-morning staff discussion about ‘High-impact and High-Prevalence risks’ to implement strategies and mitigate the risks.
* The service has reviewed and implemented policies and procedures to guide the clinical staff in assessing and monitoring consumers’ acute changes in clinical condition, post-fall and upon returning from hospital.
* Physiotherapists complete the 3-monthly consumers’ mobility care plan review and evaluation a fall risk assessment post-fall, and attend consumers’ assessments as part of the first-week admission process and when consumers return home after hospitalisation.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023 consumers said the care delivered at the service is appropriate for them and any change in condition is communicated in a timely manner and the interventions implemented were explained and agreed upon.

Based on the information contained in the site audit report I find the service has made improvements in order to rectify the deficits and is compliant with Requirements 2(3)(a) 2(3)(b) 2(3)(d) and 2(3)(e).

# 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. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The service was found non-compliant in Requirements 3(3)(a), 3(3)(b) and 3(3)(e) following the Site Audit from 6 July 2022 to 8 July 2022.

In relation to Requirement 3(3)(a), the service was not able to demonstrate it provided consistent best-practice care, specifically in relation to the management of wounds, pain, and restrictive practices.

The service has implemented a range of actions in response to the non-compliance identified at the previous Site Audit which has led to improvements made. These include:

* All wound care is now delegated to division one registered nurses.
* Clinical and care staff have engaged in ongoing training in relation to wounds.
* Clinical and management staff conduct regular toolbox sessions for each shift around issues arising from clinical care audits and incidents.
* A CCC has been appointed to ensure staff practices and clinical processes are in line with service policies.
* The pain management policy now includes specific processes to guide staff.
* Physiotherapists have reviewed each consumer’s pain management care plan.
* Restrictive practice processes, including the use of psychotropic medications, are regularly audited by clinical management.

During the Assessment Contact conducted from 22 May 2023 to 23 May 2023, consumers and representatives were satisfied the service provided effective person-centred clinical care. Care documentation reflected ongoing assessment, monitoring, and evaluation of care provided to consumers including around wounds, pain, and restrictive practices. Clinical management and staff described how they ensure consumers who experience wounds, pain and restrictive practices receive effective care.

A review of each consumer’s care file shows wounds have been accurately assessed, a treatment plan has been identified and wound review has occurred as per the assessed need. Wounds are photographed and measured according to the service’s wound care policy and regularly evaluated for pain and healing stages. Wound assessment is escalated to wound specialists and the medical practitioner when the current care regime does not result in healing. Pain is consistently monitored and evaluated through regular pain charting when consumers experience an incident such as a fall or wound, or when a consumer returns from the hospital. Non-pharmacological pain interventions are utilised as directed by the pain and physiotherapy care plans and all analgesic medications are regularly reviewed by medical practitioners.

The Assessment Team reviewed the service’s restrictive practice log and psychotropic medication register. It showed that each consumer who was subject to restrictive practices had documented evidence their representative had given informed consent for the use of the restraint and the care plan review demonstrated individualised behaviour support plans were in place to minimise the use and impact of the restraint upon consumers.

Medical practitioners have provided an indication for each psychotropic medication prescribed and reviewed the medications within the past three months. They have consulted with consumers and/or representatives regarding informed consent for the psychotropic medications and care planning documentation shows staff monitor consumers for adverse side effects associated with psychotropic medication use.

In relation to Requirement 3(3)(b) the service was not able to demonstrate there was consistency in how it managed high impact or high prevalent risk associated with care delivery specifically in relation to the management of weight, dysphagia, and mobility care for high falls risk consumers.

The service has implemented a range of actions in response to the non-compliance identified at the previous Site Audit which have led to improvement. These include:

* The review of care planning processes to ensure risk is identified and documented in the consumers’ care documentation.
* The review of weight management protocols to ensure consumers experiencing weight loss are correctly identified and weight loss prevention strategies are implemented.
* Training has been provided to new and existing staff in the area of dysphagia to enable them to assist consumers with this condition.
* Falls data has been audited to identify possible areas of concern and physiotherapy staff have presented training in prevention. Physiotherapists regularly provide education on safe transfers and manual handling.
* Clinical management and physiotherapists have revised referral processes to ensure mobility care plans are reviewed post-incident or following a change in a consumer’s condition.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023, consumers and representatives said they believed staff understood the risks associated with individual consumers and provided safe care. A review of each consumer’s care planning documents demonstrates weight and nutritional status is monitored and interventions are put in place to mitigate nutrition issues, dysphagia risk is assessed and responded to, and each consumer receives consistent post-fall care including a review of fall prevention strategies and mobility care plans.

In relation to Requirement 3(3)(e), the service was not able to demonstrate information relating to a consumer’s diagnosis, alerts, risks, condition, needs, and dietary requirements were consistently documented on the handover sheet and communicated effectively where the responsibility for care is shared.

The service has implemented a range of actions in response to the non-compliance identified at the previous Site Audit which have led to improvement. These include:

* Clinical management review progress notes daily, including on weekends, and provides staff with a list of actions to be followed up.
* There is enhanced use of emails and the electronic care planning messaging system to communicate consumer care needs.
* Clinical staff and physiotherapy staff use multiple types of handovers including daily handover sheets, weekly handover logs, and electronic messaging and alert systems to communicate consumer care information.
* Clinical management staff have oversight of care plan reviews including when consumers experience a change in health condition, post-incident, or on return from hospital.

During the Assessment Contact conducted between 22 May 2023 to 23 May 2023, consumers and representatives said they were confident staff were knowledgeable about consumers’ current needs and preferences and communicated these with other health professionals as appropriate. Consumer care planning documentation, including handover sheets, generally reflected current and consistent information about consumers’ clinical needs and preferences.

The Assessment Team viewed consumer files which evidenced input from a range of staff from within the service and external specialists as well.

Based on the information contained in the Site Audit report I find the service has made improvements in order to rectify the deficits and is compliant with Requirements 3(3)(a) 3(3)(b) and 3(3)(e).

# 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 |

Findings

The service was found non-compliant in Requirements 7(3)(a), and 7(3)(d) following the Site Audit from 6 July 2022 to 8 July 2022.

In relation to Requirement 7(3)(a) the service was not able to demonstrate they were providing a suitable mix and number of staff to enable the delivery of safe and quality care to consumers. These findings were based on feedback from consumers who felt staff did not respond to call bells in a timely manner and this impacted their care. The service also admitted at the time that unplanned leave vacancies were difficult to fill due to staff needing to isolate due to COVID-19 protocols.

The service has implemented actions to address these deficits which have been effective. These include:

* Education provided to staff on the importance of responding to call bells promptly to ensure consumers’ safety and well-being. The clinical care coordinator (CCC) conducts weekly auditing of call bell data and follows up with staff members accordingly.
* Education provided to staff members in relation to partnerships with consumers and representatives to ensure their involvement in consumers’ care planning and delivery, focusing on individual needs and preferences.
* Increased staffing ratios and mix to meet consumer's needs, and ensure safe and quality care.

During the Assessment Contact conducted on 22 May 2023 to 23 May 2023, consumers confirmed that planned actions have been implemented effectively and that they are very happy with the care provided, staff knowledge and call bells are responded to promptly. The service has increased its staffing contingent and employed an experienced and dedicated Clinical Care Coordinator. The increased staff levels have increased the minutes of care provided to each consumer and staff said they have time to interact positively with consumers throughout the day.

In relation to Requirement 7(3)(d) the service was not able to demonstrate the workforce was appropriately trained, educated and equipped to deliver quality and safe care to consumers due to staff not completing annual mandatory training and a lack of training on the use of the electronic care management system (ECMS).

The service has implemented actions to address these deficits which have been effective. These include:

* Ensured all staff completed mandatory training on the ECMS and monitored compliance to ensure staff were competent in using the system.
* Adding a user manual on ECMS in the nurse’s station to provide a reference guide.
* Educating staff on partnering with consumers when developing care plans and providing care.
* Providing staff education on and range of subjects relevant to their roles.
* Creating an education matrix using deficits in staff practices identified through incidents, feedback, observations, audits, and changes in legislation to determine education topics.

During the Assessment Contact conducted on 22 and 23 May 2023, the Assessment Team identified the service has provided a range of education sessions to staff at orientation and regularly to improve staff knowledge and ensure staff are documenting care provision competently in the ECMS. Consumers are satisfied with their care and indicated they are confident staff have the necessary skills and training to provide appropriate care.

A ten-minute training and handover meeting is held each day to discuss concerns and create strategies to provide the appropriate care for consumers.

Based on the information contained in the Site Audit report I find the service has made improvements to rectify the deficits and is compliant with Requirements 7(3)(a) and 7(3)(d).

# 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 |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found non-compliant in Requirements 8(3)(c), 8(3)(d) and 8(3)(e) following the Site Audit from 6 July 2022 to 8 July 2022.

In relation to Requirement 8(3)(c), the service was not able to demonstrate it was meeting its legislative requirements in documenting, reporting, managing and investigating incidents. Staff were not competent in using the newly installed ECMS as there had been a lack of training. There was an ineffective oversight of clinical and care staff due to poor clinical governance practices. Care documentation was not adequately reviewed as there was no Clinical Care Coordinator (CCC) to oversee this.

The service has implemented actions to address these deficits which have been effective. These include:

* All policies and procedures have been updated and reviewed to reflect best practice and current guidelines.
* A registered nurse has been appointed and trained as the infection prevention and control (IPC) lead to ensure compliance with current legislation. The IPC lead has provided education to staff on infection prevention and control practices.
* An experienced CCC has been employed to oversee and support effective clinical governance and ensure day-to-day clinical operations run smoothly.
* A quality manager has been employed to ensure audits are undertaken to inform and review the service's care delivery.
* Staff have received extensive education and training on incident management and investigation, documentation requirements, the ECMS, clinical care, Serious Incident Response Scheme (SIRS) and emergency procedures.
* Improved clinical handover to ensure the information on individual consumers is shared with all staff and handover sheets generated from the ECMS are sufficiently comprehensive to inform of consumer risks and care needs.

During the Assessment Contact conducted on 22 and 23 May 2023, the Assessment Team confirmed the service has strong and effective organisation-wide governance systems in place for oversight and management of legislative and regulatory compliance, information management, feedback management, finance, and workforce governance. The plan for continuous improvement (PCI) is regularly updated and contains opportunities for improvements, identified through a review of incidents, feedback, audit results, and observations. The quality manager prepares monthly quality reports which include an analysis of incident data, SIRS, open PCI items, and national quality indicator results.

In relation to Requirement 8(3)(d), the service was not able to demonstrate it facilitated consumers to live their best lives due to a lack of review of clinical practices and poor implementation of the incident management system. While the service had assigned the review of falls, weight loss, pain management and restrictive practices to the CCC, the position was vacant as the service had been unable to recruit appropriate staff during the COVID-19 pandemic.

The service has implemented actions to address these deficits which have been effective. These include:

* The employment of a qualified and experienced CCC.
* The employment of a quality manager
* The provision of education on restrictive practices and the creation of a flowchart outlining restrictive practices and monitoring processes to guide staff practice.
* Maintaining a psychotropic register including dates for review of consent.
* Staff education on incident reporting and investigation and identification of serious incidents.
* Staff training on the use of the ECMS to ensure all staff can readily access consumers care information.

During the Assessment Contact conducted on 22 and 23 May 2023, the Assessment Team confirmed the CCC has full oversight of all clinical care and is completing daily reviews of progress notes and assessments. The CCC documentation review ensures staff are reporting and investigating incidents correctly and where required, serious incidents are reported with timely submission to the Commission. Staff are aware of incident reporting and understand their responsibilities around reporting and investigating incidents.

Increased staffing ratios have enabled staff to better support consumers to live the best life they can. Staff described feeling less rushed with the benefits of being able to spend more time with consumers and a quicker response to call bells. Staff were observed by the Assessment Team supporting consumers to engage in activities of their choice and spending time sitting and conversing with consumers.

In relation to Requirement 8(3)(e), the service was not able to demonstrate it had an effective clinical governance system in place due to a lack of oversight and responsibility for day-to-day clinical operations.

The service has implemented actions to address these deficits which have been effective. These include:

* The development of Individualised behaviour support plans in collaboration with consumers and their representatives, medical practitioners, and other health professionals.
* Three monthly evaluations and reviews of behaviour support plans to ensure interventions remain current and effective.
* The provision of restrictive practices education for staff and inclusion of the topic as a standing agenda item at staff meetings.

During the Assessment Contact conducted on 22 and 23 May 2023, the Assessment Team found the service has implemented an effective clinical governance system to guide staff in antimicrobial stewardship, management and review of restrictive practices and open disclosure.

A complete review of policies and procedures has been undertaken by the service to ensure it meets best practice guidelines and relevant legislative requirements. Education has been provided to staff and monthly discussions on restrictive practices in line with the PCI ensure staff understand the concepts of restrictive practices and can describe non-pharmacological strategies to manage changed behaviours.

Consumer infections are reported on the monthly quality report with data trended for location and type of infections. A 6 monthly medication advisory committee (MAC) reviews infection trends and the appropriate prescribing of anti-microbials. The committee comprises a pharmacist, 2 medical practitioners, an advisory Board member, and management. The MAC reports to the Board through the advisory Board member to ensure oversight of anti-microbial stewardship.

Based on the information contained in the Site Audit report I find the service has made improvements to rectify the deficits and is compliant with Requirements 8(3)(c), 8(3)(d) and 8(3)(e).

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)