Performance

Report

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| Name of service: | Ruby Manor |
| Service address: | 10 Ruby Street CARRAMAR NSW 2163 |
| Commission ID: | 0763 |
| Approved provider: | The Sisters of Our Lady of China Health Care (2) Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 July 2023 to 7 July 2023 |
| Performance report date: | 16 August 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 Ruby Manor (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner).

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 conducted 6 July to 7 July 2023, 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 11 August 2023
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Incident Management Compliance Notice dated 14 July 2023, Assessment Contact Team report following Assessment Contact conducted on 6 July to 7 July 2023, Monitoring Assessment Contact report dated 15 June 2023, following Desk Assessment conducted on 15 June 2023, Performance Report dated 21 February 2023 following Site Audit conducted 11 January to 13 January 2023.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | 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 assessed** |
| **Standard 5** Organisation’s service environment | **Not assessed** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Not 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)(b) The approved provider must demonstrate that there is effective management of high impact or high prevalence risks associated with the care of each consumer and that comprehensive investigation to identify contributing factors and measures to prevent future incidents are developed.

Requirement 3(3)(f) The approved provider must demonstrate that there are timely and appropriate referrals to external specialists and that the recommendations of these specialists are included in strategies for consumers and reviewed for effectiveness.

Requirement 7(3)(a) The approved provider must demonstrate that there are sufficient staff to respond in a timely manner to consumer’s call bells and needs and that new staff have the appropriate buddy system to enable, the delivery and management of safe and quality care and services.

**Other relevant matters:**

The Assessment Team found that 5 of 5 assessed requirements were Not Met across the Standards. In addition, deficiencies were identified in Standard 4 Requirement (3)(a), Standard 5 Requirement (3)(b), Standard 7 Requirement (3)(d) and Standard 8 Requirement (3)(c) however these Requirements have not been fully assessed.

**Standard 1**

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

**Findings**

The Quality Standard does not have a rating as only one of the specific requirements 1(3)(a) have been assessed. The Assessment Team found that this requirement was Not Met, however the evidence that has been provided by the approved provider has satisfied me that the provider is Compliant with this requirement.

The Assessment Team found that the service was unable to demonstrate consumers are treated with dignity and respect, and their identity, culture and diversity is valued. Observations made by the Assessment Team and information from consumers and representatives show some consumers are not treated with respect and their dignity is not valued.

Information about consumer’s life history including their cultural and spiritual needs is captured in care planning documentation. Staff are aware of and said they deliver care and services in ways that consider consumers’ preferences and needs in relation to their cultural needs.

However, some consumers provided feedback that their religion was not catered for and that they were not supported to join in activities of interest to them or of cultural significance. The Assessment Team observed that staff do not consistently treat consumers with dignity and respect and that personal care for one consumer which had a flow on effect to other consumers was not managed. Behavioural supports were not considered for this consumer, despite several significant behaviours demonstrated.

The approved provider responded to the Assessment Team’s report with activities charts, diversity plan, care plan notes and photographs of consumer’s personal care and room to provide documentary evidence that the consumer’s cultural needs are respected and their identity culture and diversity is valued. The provider also provided care plan details and a dignity of risk form for a consumer named in the report.

I have considered the provider’s response and documentary evidence and this has persuaded me that the named consumers are treated with dignity and respect with the identity, culture and diversity valued.

I find that the approved provider is Compliant with Requirement 1(3)(a).

**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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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**

This Quality Standard has been found to be Non-compliant as 2 of the specific requirements 3(3)(b) and 3(3)(f) were assessed as Non-compliant.

The Assessment Team found that management of high-impact or high-prevalence risks associated with the care of each consumer has been ineffective. Consumer behaviours have been significant, resulting in poor outcomes for some consumers. Medication management is not effective in minimising risk to consumers. There have been repeated medication incidents, where there is no stock of prescribed medications. There is minimal investigation into incidents to minimise risk and improve consumer outcomes. Management advised they consider pressure injuries, medication errors, choking hazards, falls, infection control, and restraint as high-risk factors at the service.

The service identified falls as one of their high-impact, highly prevalent risks to consumers. A review of care and services documentation of consumers who have had falls showed staff are not following the organisation's policies and guidelines. Consumers who have had falls are not appropriately assessed after having a fall. Neurological observations are not attended to as per the organisation's policy, and fall risk assessments are not undertaken, and consumers repeatedly fall due to a lack of comprehensive investigation to identify contributing factors and measures to prevent future incidents have not been developed. The provider submitted documentation to demonstrate that falls have been effectively managed.

The service identified wounds as one of their high-impact, highly prevalent risks. A review of care and service documentation for consumers with wounds and pressure injuries showed these were not managed effectively. Wounds and pressure injuries were not being regularly checked, measured or reviewed as per the consumer's care plan. Photographs of wounds did not match the measurement documented in the wound chart. The wound photograph did not always have a measuring device or was not taken in line with the organisation's policy. In some instances, pressure injuries were classified incorrectly. The Assessment Team identified that pressure area incidents had not been investigated to identify the contributing factors and measures to prevent future incidents for reoccurring. The provider submitted documentation to demonstrate that wounds have been effectively managed.

The service identified behaviour management as a high-impact, high-prevalence risk. A review of care and service documentation for consumers with behaviours showed these behaviours had not been managed appropriately. Consumers with behaviours did not always have a behaviour support plan. For some consumers, behaviour care plans did not contain enough information about triggers and interventions. These have had frequent and significant impacts on the consumer, other consumers and the staff. The risks to the consumer and other consumers due to the changed behaviours have not been effectively managed with an ongoing risk to the health, safety and well-being of the consumer, other consumers, and risks to staff.

The service has identified 2 floors of the home to be environmentally restrained for consumers. While there is consent and authorisation for environmental restraint, there is no risk assessment or monitoring of the restraint. Consumers under environmental restraint easily mobilised up and down the coded lift unsupervised.

The Assessment Team identified that the service did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services associated with each consumer where required. While the service has referred consumers to external services, it is not attended to in a timely manner after a serious incident or accident. The service has support services such as dementia support, onsite physiotherapist and dietitian services.

The Assessment Team identified for 3 consumers who have escalating behaviours of concern, they have not been referred in a timely manner to external specialists despite their increasingly unmanaged behaviours of concern.

The Assessment Team identified that service has infection prevention policies and procedures and an outbreak management plan. During the Assessment Contact, the service required daily rapid antigen testing (RAT) for all staff, visitors and contractors. Staff and visitors were wearing surgical masks; however, several staff practice breaches were observed. Registered nurses described infection control practices they implement to reduce infection risks, such as hand hygiene, increasing fluid intake and monitoring consumers for symptoms. However some staff were observed pulling their masks below their chin while talking to consumers.

Registered nurses interviewed demonstrated an understanding of antimicrobial stewardship and said they refer consumers to medical officers for laboratory testing before antibiotic usage.

The Assessment Team observed practices throughout the Assessment Contact which did not demonstrate effective minimisation of risk related to infection control. During the Assessment Contact, the Assessment Team observed several staff throughout the service with masks below their noses. Most staff were frequently observed touching their mask without proper hand hygiene. Poor communication about infection-related risk was noted during the Assessment Contact. The provider submitted training records and evidence of their infection control processes.

The approved provider responded to the Assessment Team’s report with comprehensive information including the Plan for Continuous Improvement, physiotherapist care plans and notes, neurological observations, copies of incident reports with related investigations and May falls meeting minutes, wound care information, dignity of risk forms and repositioning charts. Medication administration reports, care planning documentation and training records were also furnished. The provider also advised that strategies implemented for the consumer who sustained several falls have been successful with the consumer not having any falls for 3 months.

I have considered the compelling information that has been provided in response to requirement 3(3)(g) and the examples that the provider has listed. I have place weight on the providers feedback in relation to this requirement and the training that has been provided to staff on infection control, I also note that there was confusion with two staff who had called in unwell and how this was reported. I am satisfied with the information that the provider has furnished and find that the approved provider is Compliant with requirement 3(3)(g).

Whilst I have considered the comprehensive information and actions that the provider has initiated, I believe that the high impact and high prevalence risks have not all been treated and I find that it will take some time to reflect compliance in particular with staff effectively managing behaviours of consumers that have a flow on effect to other consumers. I have considered the providers response to requirement 3(3)(f), I however do not find that there was a timely referral for some consumers who are subject to responsive behaviours that are impacting on other consumers.

I find that the approved provider is Compliant with requirement 3(3)(g) and Non-compliant with requirements 3(3)(b) and 3(3)(f).

**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. | Not assessed |

**Findings**

This requirement has not been assessed. Information has been provided in relation to deficiencies identified.

The Assessment Team interviewed consumers and representatives who provided mixed responses with regard to the service meeting their needs, goals and preferences and optimise their independence. Some sampled consumer interviewed provided feedback that they are happy with the service and the staff and enjoy the activities on offer. However some consumers are not provided with sufficient individual engagement in meaningful activities.

The Assessment Team spoke with representatives and reviewed care planning documentation. One representative said that their consumer does not get enough therapeutic activities, is not provided with meaningful activities or assistance with exercises even though the consumer is gaining weight. A review of care planning documentation did not demonstrate that Dementia Service Australia recommendations had been considered for meaningful activities or that sufficient information was included in care plans with regard to life stories to allow the consumer effective activities to engage in or that they may have been interested in.

The approved provider provided their Plan for Continuous Improvement with initiatives to review consumers with behaviours and their activities and lifestyle needs.

**Standard 5**

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not assessed |

**Findings**

This requirement has not been assessed. Information has been provided in relation to deficiencies identified.

The Assessment Team identified that the service environment is not always safe, clean and well maintained and comfortable. The Assessment Team observed several deficiencies with several of the consumers doors and walls in corridors were found to be badly scuffed and in need of repair or painting. Patches were observed on walls where shelves had been removed and curtains were missing in the dementia support unit on level 2. There was little or no furniture in the small activity areas at the end of corridors on levels 2 and 3.

Common bathrooms on all levels were observed to contain furniture, lifters and wheelchairs. The facility manager said that they were not used as bathrooms but as storage areas due to lack of space to store furniture and said these rooms should have been locked. However, a 'bathroom' sign was still on the doors and rooms could only be locked from the inside.

The Assessment Team also observed that the toilets in the common bathrooms were being used by consumers with toilet paper rolls in place. Bathrooms were found to be dirty and used paper towel lying on the floor, with the toilets not cleaned. Staff were observed assisting 2 consumers to the common bathroom during the Assessment Contact.

A hand washing basin on level 2 was observed to have used paper towel in the basin and on the floor and a wet patch behind the basin. The utility room door on level 3 was left open. It contained cleaning products and dirty linen and bins. A storage room on level 2 was observed unlocked and open and contained PPE, furniture and a clean linen trolley.

The services continuous improvement plan of January 2023 documented that painting needed to be done and curtains needed replacing, however no further information with regard to planned actions or completion dates were identified. The continuous improvement also did not identify planned actions for replacing furniture or how this would be managed in the interim since furniture had been removed.

The property manager was not aware of the service maintenance system for routine and preventative maintenance or any environmental audit to routinely check the facility for maintenance/repairs/hazards.

The Provider forwarded their Plan for Continuous Improvement which listed that all the painting has been completed and other furnishings had been ordered. The equipment that has been stored in a bathroom will be moved to another secure space that has been located with some renovation work required, however bathrooms have been restored for consumer and visitor use.

**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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not assessed |

**Findings**

The Quality Standard has been found to be Non-compliant as one of the specific requirements 7(3)(a) was assessed as Non-compliant.

The Assessment Team identified that the service does not have sufficient numbers of staff to ensure the delivery and management of safe quality care and services. Whilst workforce planning occurs, the significant number of consumers at the service with high individual needs is not being managed by the staff deployed. Staff and consumers have commented on the shortage of staff impacting on consumers care and safety.

One representative provided feedback to the Assessment Team and said the place is okay, but that the consumer is unhappy there and believes the staff are caring, however there are not enough staff to provide therapeutic activities for the consumer. The representative said that although the consumer participates in activities, the consumer feels they are demeaning as they are geared to consumers with more advanced dementia.

Another representative said there were not enough staff and said, 'some staff are good, and some are not'. The representative said that one staff has been rude to consumer and leaves the medication on the table for the consumer although the consumer does not self-administer medications. The same staff has removed the consumer’s dinner plate before the consumer had finished eating. When the consumer complained the staff member said they had to finish their job. The representative also provided an example of where the consumer needed to go to the bathroom and rang the call bell which was answered but staff said they would return in 10 minutes however it was 1 hour later.

Representatives said that sometimes staff were hard to locate when they visited consumers. Several representatives of consumers in the dementia support units did not have family representatives but used the Public Guardian to advocate for them. These were not able to be contacted.

Staff interviewed commented that the service was short of staff, and they could not care adequately with the significant numbers of consumers with high cognitive impairment. One staff member interviewed said, it is very hard to do everything, especially with the 'behaviour of residents'. The staff member advised the Assessment Team that it is often difficult to finish all the work and they must pass work on to staff on the following shift. The staff member advised that some staff do double shifts when they are short staffed and a lot of staff are stressed. During the interview the Assessment Team observed 5 consumers wandering around the activity/dining room waiting for their meals with no other staff in the area at the time to engage with them.

The facility manager said she has the correct number of staff according to staff ratio's set by the organisation. She advised that there were no unfilled shifts, and any vacant shifts are filled with casual staff, staff doing extra shifts and occasional agency staff.

Staff rosters are reviewed regularly by the facility manager to ensure there are enough staff and she will move staff around as necessary, for example, she said the afternoon shifts will sometimes only have 2 staff because staff may be relocated to other areas as needed. When there are vacant shifts, staff will be called in from the casual pool of staff or some staff are asked to work extra hours. She said an extra 8 staff have recently been employed in casual positions and are in the process of onboarding.

The Assessment Team observed several staff being relocated to other levels due to staff absence or an incident had occurred. Some staff were moved from the laundry to the serving area.

Service guidelines require call bells to be responded to within 8 minutes. The facility manager said that if it is longer than this staff will be asked to explain. Call bell records were not provided when requested by the Assessment Team. It was noted that not all consumers are able to use the call bell, with most consumers residing in the dementia support units.

Falls management meeting minutes reviewed indicated a significant number of falls at the service with the highest number in June 2023 at 6pm during the staff break time.

The Assessment Team observed consumers disengaged and wandering in both the services dementia support units throughout the Assessment Contact. On several occasions consumers were observed shouting at other consumers or staff and other consumers becoming agitated as a result.

The approved provider responded to the Assessment Team’s report with comprehensive documentation including activities sheets, case conference notes, rosters and information pertaining to the increased shift to address sundowning and staff education and induction paperwork.

Whilst I have considered all of the information that the provider has furnished, I note the impact that the consumers and staff spoke of and the assessors observed with consumers not being actively engaged, or the staff not being available to assist consumers when they were waiting in the dining room.

I find that the approved provider is Non-compliant with this requirement 7(3)(a).

This requirement 7(3)(d) has not been assessed. Information has been provided in relation to deficiencies identified.

Management provided training and education records which indicated that some training had been conducted in 2023. However, information from consumers and staff and observations by the Assessment Team identified gaps in staff skills and knowledge. Management advised the service provides annual mandatory training in, manual handling, fire, infection control and SIRS.

Staff competencies training include medication administration, handwashing and donning and doffing. Staff interviewed said they had received training in dignity and choice, dementia, open disclosure, SIRS, manual handling and infection control in 2023, however other staff said they had not received this training.

Staff meetings have been held via zoom and one staff member said that only 1 staff can go to the meeting from each area as staff need to look after consumers in their areas. It is unclear if meeting minutes were provided for staff who could not attend.

The services continuous improvement plan includes a 'management initiative' for supporting psychosocial health of the staff and manager on 21 June 2023 and behaviour management training for 16 March 2023, however no further information was provided with regard to actions taken or progress.

Throughout the Assessment Contact, the Assessment Team identified gaps in staff practices for infection control, environmental restraint, behaviour management and manual handling indicating that while training may have been provided in these areas that it has not been effective.

The approved provider responded and advised that they will ensure that training is delivered on time and is of good quality and will work on performance monitoring management to ensure that they have a skilled and qualified workforce.

**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. | Not assessed |

**Findings**

This requirement 8(3)(c) has not been assessed. Information has been provided in relation to deficiencies identified.

The Assessment Team identified issues regarding the organisation’s electronic consumer records management system ‘patient centred software.’ The system provided limited reporting capabilities. When asked by the Assessment Team for records indicating trending data for complaints, incidents or clinical indicators, staff said the system did not allow them to access all this data, but they would endeavour to provide what they could. The service was unable to provide accurate data relating to the service’s clinical indicators for the past 3 months

The system does not automatically populate consumer information as required to ensure an effective, easily accessible information for staff to review. For example information in consumer’s behaviour support plans does not populate into their care plans and must be manually input. Recommendations from other service providers, such as Dementia Support Australia needs to be scanned into the system.

Staff commented that the system is not easy to navigate and does not provide the necessary information in a timely manner.

During the Assessment Contact the internet at the service was ‘down’ and records not able to be accessed for some time. The services laptops used by the Assessment Team to review consumer records often automatically shut down.

Management acknowledged that the electronic consumer record system currently in use is not user friendly and are considering improvements to make it easier to navigate and report. Management advised that the organisation is looking to replace the system however could not provide any further information or timeframe. The organisation’s continuous improvement plan did not identify this issue.

The organisation does not have an effective incident management system to mitigate significant incidents at the service, and deficiencies in the implementation of interventions is not evaluated and documented. Management and staff do not have a good understanding of managing consumers with changing behaviours. The organisation did not provide sufficient evidence that the service is undertaking a thorough investigation of incidents to determine the nature and contributing factors leading to incidents in accordance with best practice guidelines provided by the Commission. This includes, identifying risks to consumers, analysing incidents, and putting strategies in place to mitigate risk and prevent incidents from reoccurring.

Strategies put in place in behaviour support plans are often generic and are not analysed for effectiveness and continue to occur.

The organisation’s continuous improvement plan of 3 March 2023 identified the number of increased behavioural incidents and identified the need to focus on behaviour management support/management for the consumers living in the dementia support units. Planned actions include additional training and setting up a project team in conjunction with the lifestyle team for staff training in dementia and overall consumer engagement in lifestyle activities. There is no information with regard to how the service will support individual consumers in managing their changing behaviours.

The approved provider responded to the Assessment Team’s report and acknowledged that there are shortcomings of the electronic management system, however there are manual workarounds and are currently reviewing their system as part of the plan for Continuous Improvement. To do this, they need to plan and implement any major system change to minimise impacts on documentation and workflow and benefits of any new system for productivity and compliance.