Performance

Report

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| Name: | Serene Residential Care Services |
| Commission ID: | 6820 |
| Address: | 1 Myzantha Street, LOCKLEYS, South Australia, 5032 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 August 2024 to 7 August 2024 |
| Performance report date: | 23 August 2024 |
| Service included in this assessment: | Provider: 3424 Blu Dawn Pty Ltd  Service: 4264 Serene Residential Care Services |

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 Serene Residential Care Services (**the service**) has been prepared by M Glenn, 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.

# 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, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* a performance report dated 19 January 2024 for a site audit undertaken from 4 December 2023 to 6 December 2023.

The provider did not submit a response to the assessment team’s report.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not fully assessed |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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)(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)(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

**Requirements (3)(b) and (3)(e)** were found non-compliant following a site audit undertaken in December 2023 as care, behaviour support and lifestyle planning was not individualised, did not address consumers’ needs and goals, or reflect all falls management and prevention strategies; and consumers’ care was not reviewed appropriately when circumstances changed and impacted on consumers’ needs. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, recruitment of a care manager to support review of assessment and planning processes; reviewed all care plans and assessments to identify or review end of life goals of care; implemented record of discussion and reflective practice forms between management and clinical staff where gaps in care documentation are identified; and undertaking reviews post allied health reviews and transitions of care to ensure care documentation is reflective of required care needs.

At the assessment contact undertaken in August 2024, assessment and planning was found to identify and address consumers’ current needs, goals and personal preferences. Care files include detailed, personalised information about consumers’ needs, goals and preferences related to personal and clinical care, mobility needs, and emotional, social, spiritual and cultural support. Advance care and end of life planning discussions with consumers and representatives commence on entry, and occur ongoing as required and at care plan reviews. Consumers’ end of life needs, goals and preferences are captured in a palliative care plan, and advance care directives and end of life pathways are in place.

Consumers and representatives said the service reviews consumers’ care and notifies them of any changes, especially following incidents or when deterioration or change in condition is identified. Care plans are reviewed routinely every three months and as required, and care evaluations occur monthly. Monitoring processes, such as 24-hour progress note reviews, buzz meetings with staff, monthly care evaluations, post external staff review evaluations and weekly high risk meetings identify and facilitate discussions of any changes in consumers’ needs, goals and preferences and ensure timely reassessment. Care files demonstrate review, monitoring and reassessment of consumers’ condition, care and service needs post incidents, in response to weight gain/loss, and following reduction in psychotropic medications. Care files also evidence referral to and involvement of allied health professionals in the review process, with resulting recommendations incorporated into care plans to guide staff in provision of consumers’ care.

Based on the assessment team’s report, I find requirements (3)(b) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | 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)(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 |
| 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

**Requirements (3)(a), (3)(b), (3)(d) and (3)(e)** were found non-compliant following a site audit undertaken in December 2023 as consumers did not receive safe and effective clinical care relating to management of fluid restrictions, blood glucose level monitoring, falls and weight loss; risks associated with medication administration and behaviour support were not minimised or effectively managed, and psychotropic medications used in the form of chemical restraint were not effectively identified; deterioration was not appropriately responded to; and consumers’ conditions and needs were not effectively communicated within the organisation. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, a new audit tool for diabetes management; education to staff on wound management, pain management, palliative care and recognising and responding to deterioration; reviewed consumers’ pain management, with escalation to medical officers and allied health professionals, where indicated; and introduced a urinary tract infection clinical pathway and delirium screening pathway.

At the assessment contact undertaken in August 2024, consumers and representatives said consumers receive personal and clinical care that improves their health and well-being, and are satisfied with management of identified risks associated with consumers’ care. Care files sampled evidence appropriate, best practice care relating to management of diabetes, wounds, pressure area care, and urinary catheters. There are processes to identify, assess, plan for and mage high impact or high prevalence risks relating to consumers’ care. Care files evidence effective management of risks relating to behaviours, restrictive practices, time sensitive medications, falls and fluid overload. Care files also evidence involvement of allied health and medical officers in assessment and management of identified consumer risks.

Where a change or deterioration in consumers’ condition has been recognised, care files show increased monitoring is undertaken, charting and assessments are completed, and referrals to medical officers initiated, and where required, consumers are transferred to hospital for further review and follow-up. Consumers and representatives are confident in the workforce, stating staff know consumers well enough, and are able to recognise and effectively respond to any changes in their condition.

There are processes to ensure information about each consumer’s needs and preferences is documented and communicated. Care files show following review by allied health and specialist services, consumer care plans are updated to incorporate recommended interventions. Care files for two consumers who had returned from hospital include discharge information, updated care plans, and appropriate follow-up actions, such as medical officer reviews. A seven-day handover sheet is used to document daily updates for consumers, with the registered nurse in charge completing updates for each shift. Verbal handover processes are also conducted where shift specific information is shared, and any necessary follow ups communicated. Buzz meetings are held whenever a gap in processes or care is identified, and provide an opportunity for management to reinforce expectations and ensure care aligns with consumers’ needs and preferences. Consumers expressed confidence in staffs’ understanding of their needs and preferences and said care is delivered according to their wishes.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 3 Personal care and clinical care 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

**Requirements (3)(c) and (3)(d)** were found non-compliant following a site audit undertaken in December 2023 as clinical and care staff did not have the knowledge to effectively perform their roles to ensure safe and effective care delivery; and the workforce was not trained and supported to deliver safe and effective care and services. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, a competency schedule for care and clinical staff, with specific competencies required to be achieved each month; a consumer care coordinator, responsible for overseeing floor-level practices; reviewed and updated all job descriptions and duty statements; streamlined onboarding and recruitment processes; and implemented a training schedule for the year that includes mandatory and optional training.

At the assessment contact undertaken in August 2024, consumers and representatives expressed confidence in the workforce, stating staff are competent, appropriately skilled and well trained. An annual competency schedule has been implemented for clinical and care staff covering areas, such as behaviour management, oral/dental hygiene, medication administration, blood glucose level monitoring and wound care. Competency completion rates show all relevant staff have met the required competencies each month. The consumer care coordinator is responsible for completing competency assessments for care staff, and the clinical nurse conducts competency checks for clinical staff. There are processes to address situations where competencies are not achieved, such as additional mentoring or performance management. Staff said they complete monthly competency assessments, which they view as an opportunity to receive feedback on performance and important for personal development.

There are systems and processes to ensure staff are properly recruited, trained and equipped to deliver care and services. Staff undergo role-specific orientation and onboarding, which is guided by a newly implemented orientation checklist. This process includes mandatory training and competency assessments, with new staff paired with experienced staff when they begin work. An annual education schedule has been developed, with monthly training sessions that include all mandatory and optional training. Mandatory training covers topics, such as restrictive practices, infection control, antimicrobial stewardship, the serious incident response scheme (SIRS), open disclosure, the Quality Standards. Staff training records show completion rates for mandatory training are over 99%. Consumers and representatives feel staff have adequate training to equip them to perform their roles effectively.

Based on the assessment team’s report, I find requirements (3)(c) and (3)(d) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| 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

**Requirements (3)(b), (3)(c), (3)(d) and (3)(e)** were found non-compliant following a site audit undertaken in December 2023 as the organisation’s governing body did not promote a culture of safe and quality care; governance systems relating to information management and workforce governance were not effective; risk management systems and practices, specifically relating to high impact or high prevalence risks and use an incident management system to manage and prevent incidents were not effective; and an effective clinical governance framework was not demonstrated. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, an audit schedule to test the service’s systems and processes across key areas of care and service provision, with reporting lines established to ensure audit outcomes are reported to the board of directors (the board); increased and ongoing staff training programs to improve staff knowledge and address identified deficits in care documentation and delivery; reviewed the workforce plan to ensure sufficient staffing to meet consumers’ needs, goals and preferences; and established two additional clinical staff positions to increase clinical oversight, strengthen clinical governance, and effectively monitor staff work practices.

At the assessment contact undertaken in August 2024, the organisation was found to be governed by a board who are supported in their role by sub-committees designed to conduct initial analysis of quality indicators of care and service data, implement management strategies, and report actions to the governing body at regular intervals. Governance processes include compliance monitoring through internal and external auditing programs, strategic planning, financial and risk management which are embedded in policies and procedures. There are established systems and processes to collect, analyse and trend clinical, incident and feedback data, which is discussed at service, executive and board meetings. A consumer advisory committee, in line with legislative requirements, has been established to ensure promotion of inclusive, safe, quality care and services. An audit program enables the organisation to self-identify issues in key areas of care and service provision, with learnings shared across relevant committees and reported to the board. All consumers and representatives said the service is well run, stating management listens and are receptive to feedback. Consumers and representatives are satisfied with communication from management and the board, which is received through newsletters, emails and face-to-face conversations.

A documented governance framework and systems, overseen by the board, describe key elements and provide an overview of governance systems, components, and tools. The framework defines the rules, relationships, systems, and processes by which authority is exercised and controlled within the service. An electronic care documentation system is accessible to all clinical and care staff, and reports, policies and procedures, consumer, representative and staff forums and handover processes are used by the service to provide stakeholders with up to date, relevant information. The organisation has a continuous improvement framework with established processes to gather information from a range of sources to improve care and services. A plan for continuous improvement is maintained and includes improvement actions, completed and/or ongoing, across the eight Quality Standards. Financial governance is overseen by the board who monitor and review financial performance, income, and expenditures and delegate authority to different levels of management where appropriate. Workforce governance processes and a suite of policies and procedures guide staff and provide parameters for performance management, skills assessment, and training. Human resource processes oversee staff development and support service management and staff in relation to performance and industrial relation matters in line with legislative requirements. Changes in aged care legislation and regulations are monitored by maintaining subscriptions to legislative update services, and memberships of peak bodies and associations, with reporting responsibilities to ensure changes are conveyed and actioned throughout the service. Established feedback and complaints mechanisms support the capture and analysis of feedback data, with reporting lines ensuring communication of any trending complaints or themes to the board.

There are effective risk management systems and practices in place. High impact or high prevalence risk data is identified through clinical assessment and incident review, with monthly reports developed and tabled at service and management level committees for further analysis, trend identification and risk minimisation or elimination, with escalation to the board where required. Incident reporting policies and procedures guide staff, supported by SIRS training. SIRS incident data is included as part of monthly data reports provided to the board and sub-committees for further analysis and action where required. SIRS incident data shows the reporting of 12 incidents within mandatory reporting obligations between January and May 2024. Actions taken in response to incidents include implementation of mitigating strategies to prevent reoccurrence, staff performance management where required, and use of open disclosure. Staff are guided in relation to supporting consumers to take risks through individual risk assessments that identify risks and strategies to mitigate them. An incident management system, supported by policies and procedures to guide staff practice, captures incident data which is analysed monthly to identify trends and develop strategies to reduce reoccurrence, with reporting lines in place to ensure oversight by the board and other sub-committees, where appropriate.

Clinical care is governed by an overarching clinical governance framework, which includes robust clinical processes, such as assessment and review of consumers’ care needs, incident reporting and review, staff training, and policies and procedures to ensure staff provide consistent clinical care. An infection control policy outlines the organisation’s approach to the ongoing monitoring of infections and responsible use of antimicrobials. Tracking, analysis, trending, and reporting processes ensure clear oversight by the clinical governance committee. Monthly infection summary reports from January 2024 to July 2024 evidence analysis of antimicrobial use, including whether pathology has been sought prior to antibiotic prescribing. Policies and procedures support and guide staff in the responsible use of restrictive practices and reflect current legislative and regulatory requirements. Assessment, review, monitoring and reporting processes, as well as staff education are utilised by the service to minimise restrictive practice use. A psychotropic register is maintained and shows ongoing monitoring of medications used for restrictive practice, regular review by medical officers and reduction or ceasing of medication use where possible. Monthly reports of restrictive practice use are submitted to the board and clinical governance committee. Open disclosure principles are embedded in incident and complaint management practices and staff education supports the service’s commitment to the use of open disclosure when things go wrong. Incident and complaints reporting and review processes ensure appropriate investigation to identify strategies for the prevention of reoccurrence.

Based on the assessment team’s report, I find requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)