Performance

Report

**1800 951 822**

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| Name of service: | Southern Cross Care North Turramurra Residential Aged Care |
| Service address: | 402 Bobbin Head Road NORTH TURRAMURRA NSW 2074 |
| Commission ID: | 0173 |
| Approved provider: | Southern Cross Care (NSW & ACT) Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 September 2022 |
| Performance report date: | 2 November 2022 |

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 Southern Cross Care North Turramurra Residential Aged Care (**the service**) has been prepared by Melissa Buhagiar, 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
* the provider’s response to the Assessment Team’s report received 24 October 2022
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Previous compliance history including Directions Notice dated 17 September 2021.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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 2(3)(a) The approved provider must demonstrate that assessment and care planning is reviewed to reflect consumers current conditions and risks associated with their conditions.

Requirement 2(3)(b) The approved provider must demonstrate that the consumer’s current needs, goals and preferences, are accurately articulated within their care plans.

Requirement 2(3)(e) The approved provider must demonstrate that the care plans are reviewed regularly and include effective strategies when the consumer’s condition changes or when circumstances change or when incidents impact on the needs, goals or preferences of the consumer and that incidents are investigated to identify the cause of incidents.

Requirement 3(3)(a) The approved provider must demonstrate that each consumer gets safe and effective personal care, clinical care, and this care is accurately documented. Behaviour management and support plans contain triggers for behaviour and mitigations strategies individualised to support the consumers.

Requirement 3(3)(b) The approved provider must demonstrate that high impact or high prevalence risks associated with the care of each consumer are reviewed regularly and monitored for effectiveness.

Requirement 3(3)(d) The approved provider must demonstrate that all staff are trained and can recognise deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition and respond and escalate this in a timely manner.

Requirement 7(3)(e) The approved provider must demonstrate that the current overdue performance appraisals are completed and regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

Requirement 8(3)(d) The approved provider must demonstrate that there is effective organisational risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers.

**Standard 1**

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| Consumer dignity and choice | |  |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

**Findings**

The Assessment Team interviewed consumers and representatives who confirmed that their privacy is respected. Consumers advised that staff knock on their doors before entering.

The Assessment Team interviewed care staff who were able to describe the practical ways they respect the personal privacy of sampled consumers, including knocking and waiting for a response before entering their rooms, and maintaining confidentiality of consumers when they had contracted COVID. The service provided a policy on ‘Dignity, Choice and Respect’ that included respecting consumers’ privacy and keeping their personal information confidential. Overall, the Assessment Team observed staff respecting consumers’ privacy and dignity when delivering care and services and staff were aware of the service’s policy on privacy and confidentiality. However, one member of the care staff was observed to enter a consumer’s room without knocking while the consumer was being interviewed by the Assessment Team.

This requirement was previously found to be non-compliant from a Site Audit conducted 31 May 2021, however it was noted by the Assessment Team that the previous issues related to privacy have since been addressed.

I find that the approved provider is Compliant with this requirement.

**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. | Non-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. | Non-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. | Non-compliant |

**Findings**

The Assessment Team interviewed consumers and representatives who mostly provided positive feedback in relation to assessment and planning with representatives saying that they are informed when there is a change. However, care and service documentation did not provide evidence of comprehensive assessment and care planning that considers risk to the consumer’s health and well-being and review is not conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals or preferences of consumers. Care plans and assessments were incomplete or not completed.

The Assessment Team spoke with one representative who advised that they had received a copy of the care plan after requesting it and there was a large amount of incorrect information. The representative advised that staff had asked the representative to review the care plan and mark what was incorrect and return it to them. A review of care and service documentation for the consumer identified that care planning was not reflecting the consumer’s current needs, behaviour management, pain management and contained generic goals of care.

The Assessment Team reviewed care plans and identified for the sampled consumers that the care plans did not consider current risks associated with their condition or diagnosis. When pressure injuries were noted as a current cause of pain for one consumer, there were no documented pressure or wound injuries noted. There were deficits identified for consumers at risk of falls without known diagnosis considered and behaviour support plans did not identify specific triggers.

The Assessment Team found that care needs are not reflected accurately in care planning domains, such as the provision of personal care and restrictive practices care planning does not reflect the type of restrictive practice the consumer is subject to. Pain assessments were not routinely undertaken for consumers or documented when the consumer was in pain and not assessed following falls.

The organisation has policies and procedures in relation to assessment and care planning. Staff were able to describe the needs and preferences of sampled consumers. However, a review of care and service documentation for sampled consumers showed their current needs, goals and preferences were not always documented.

The approved provider responded to the Assessment Team’s report and provided evidence of updated care plans and progress notes for consumers and restrictive practice authorisations for sampled consumers, the provider also advised that a case conference had been conducted to address the inconsistencies identified in the care plan for the noted consumer prior to the Assessment Team’s visit, however the representative still expressed dissatisfaction when speaking with the Assessment Team, after this case conference. A continuous improvement plan was provided with actions including that the clinical team will review consumers care plans to identify gaps, with random management audits of care planning documentation, education for staff for palliative care and deterioration and to review and update the psychotropic register.

I have considered the additional and updated information that the approved provider has furnished, and the actions that they have taken since the assessment visit, however understand that it will take some time to review the care and assessment plans to reflect current and individualised needs for consumers.

I therefore find that the approved provider is Non-compliant with these requirements.

**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. | Non-compliant |
| 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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. | Non-compliant |

**Findings**

The Assessment Team found that the service was not able to consistently demonstrate consumers receive safe and effective personal or clinical care that is tailored to their needs, is according to their preferences, and best practice. While some adjustments had been implemented to one consumer’s care plan which was sampled during the last site audit, it was identified overall that sampled care plans did not reflect the current needs of the consumers. Positive feedback was received from some consumers and representatives regarding care provision and staff attentiveness. However, one representative said they were not happy with how the service managed their consumer’s current condition.

The Assessment Team found that where pain was identified, interventions were not recorded as provided in a timely manner and pain was not recorded as having been reassessed. Consumer pain was observed to not always be assessed according to the service’s policy and procedure guidance.

The psychotropic register contained gaps including missing information and review dates that had not been updated. Several consumers were noted to be prescribed medications which were not recognised as a treatment for their respective diagnoses. Several consumers did not have a reason for prescribing documented. Most of these consumers were observed to have been prescribed a schedule 8 pain relief.

Review of behaviour management care plans and behaviour support plans reflected consumer diagnoses are recorded as triggers for behaviours, indicating the staff have not investigated the true cause for their behaviours. Behaviour charting was not always reflective of adverse behaviours.

The Assessment Team’s review of sampled clinical documentation reflected the service is not effectively planning for or managing consumers high impact or high prevalence risks. The Assessment Team identified risks with the management and monitoring of consumers diagnosed with diabetes, falls prevention and management and post falls management. This includes the completion of neurological observations according to service policy and procedure.

The service did not demonstrate that the needs, goals and preferences of all consumers nearing end-of-life are recognised and addressed. Some palliative and end-of-life care plans reviewed were generic in nature. Preferences expressed in advance care directives were not always followed by the service. The service was unable to provide monitoring and review charts for end-of-life comfort care for some sampled consumers who had passed.

The Assessment Team found that the service did not demonstrate recognition and responding to deterioration or changes to a consumer’s mental health, cognitive or physical function, capacity or condition in a timely manner. Representative feedback and documentation of consumers who have had a change in their condition did not demonstrate that timely response is being attended.

Documentation reviewed reflected staff at the service failed to recognise and respond to the declining condition of a consumer and failed to notify the consumer’s representative of the decline prior to the consumer passing. The review of care and service documentation shows appropriate assessments and escalation to the medical officer was not undertaken.

The approved provider responded to the Assessment Team’s report and acknowledged that documentation was not always in line with the expectations of the organisation and that there was scope for improvement. The provider advised that staff had been provided with additional education. The provider advised that the gaps identified in the psychotropic register were due to the register being updated monthly in correlation with their psychotropic report and this was now in order. The approved provider acknowledged that behaviour management and behaviour support plans did not record correct information in relation to consumer’s triggers for behaviours and that they staff will be having education to understand triggers and what constitutes a behaviour, the service will also undertake a review of behaviour support plans to ensure that correct triggers are identified. The continuous improvement plan contains additional initiatives to address the gaps identified including clinical staff meeting to discuss the detection of deterioration, palliative and end of life care, falls management and falls risk prevention. In response to the Assessment Team’s findings for individualised palliative, end of life plans and advance care directives, additional information was provided and progress notes for consumers reaching end of life to support the provider’s compliance. This additional information provided evidence that the care was provided and documented, and the families considered that they were kept informed and appreciative of the care provided.

I have considered the additional documentation that the approved provider has submitted and find that there are areas of improvement in relation to providing the consumer with safe and effective personal care, clinical care, effective management of high impact or high prevalence risks and recognising and responding to the deterioration or change of a consumer’s condition in a timely manner. This has been acknowledged by the provider and included in their continuous improvement plan, and I find the requirements 3(3)(a), 3(3)(b) and 3(3)(d) to be non-compliant. I however, find with the evidence that has been provided in relation to requirement 3(3)(c), that the provider has demonstrated that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

I find requirements 3(3)(a), 3(3)(b) and 3(3)(d) to be Non-compliant and requirement 3(3)(c) to be 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 |
| 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)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

**Findings**

The Assessment Team found that the service was unable to demonstrate that the workforce is planned to deliver and manage safe quality care and services to consumers. While consumers sampled were generally positive about staffing levels one staff member said, “they are unsure what is happening with staffing” and that staffing levels are impacting on consumers. Review of unplanned leave and the master roster identified a number of unfilled shifts for the month of September 2022 and review of call bells identified a significant number above the 10-minute timeframe set by the service.

The Assessment Team acknowledges that the service has made some improvements to staffing capacity and levels since the last visit including; additional care staff hours on the AM shift, an additional registered nurse to undertake care planning activities and the engagement of an additional employment agency to supplement the existing 5 agencies. Management also advised that recruitment is ongoing, and they are currently looking for one registered nurse and as many care staff as they can employ.

The Assessment Team interviewed staff who said that they often need to do double shifts with the most recent request being the day of the assessment contact and prior to that the week before. The care staff said there are a lot of new staff and this makes work harder because they don’t know the consumers. The care staff said the impact on consumers is that they do not receive care in line with their preferences providing the example of showering which may not be done each day or at their requested timeframe. They also said some consumers who are on close watch and sight charts cannot be observed as staff are assisting others and this is contributing to consumer falls.

The Assessment Team reviewed call bell data which identified the service had a large number of call bells exceeding 10 minute timeframes as set by the service. Approximately 50 of these calls were in excess of 1 hour. Management advised they are reviewing call bell data and have recently received approval for a new call bell response system which is due to be implemented in coming weeks.

The Assessment Team found that staff have the appropriate qualifications to perform in their roles and management advised they ensure staff are competent through completion of annual mandatory training modules. However, when reviewed management identified some mandatory training and assessment modules have not been completed by all staff and these deficiencies have impacted on the care and services for some consumers. Review of four staff across care staff and registered nurses identified none have completed manual handling, infection control and fire training in the past 12 months.

The Assessment Team interviewed management who advised that the service has a process in place for annual performance appraisals and more regular review processes for new employees during probation periods. However, management identified that performance appraisals are not up to date. The service was unable to demonstrate how feedback provided through performance appraisals is identified, monitored, reviewed and implemented in a timely manner.

Management told the Assessment Team that approximately 80 percent of performance appraisals have been submitted by staff and are waiting on manager approval. While approximately 13 percent have been completed and approximately 6 percent are new employees. The facility manager told the Assessment Team they have not signed off on the performance appraisal as they have been at the service since May 2022 and don’t have enough knowledge of staff to comfortably and fairly sign off on the appraisals and showed the team a memorandum that has been sent to employees about the extension period for performance appraisal completion. The memorandum (dated July 2022) states that the completion date for annual appraisals has been extended to the end of September 2022.

The approved provider responded to the Assessment Team’s report and provided clarification and further evidence supporting their compliance with these requirements. The provider furnished call bell data that had been filtered without door alarms which represented many the calls exceeding 10 minutes. The information provided clarity that the large number of calls were less than 10 minutes with highest call duration at 17 minutes. The provider advised that recruitment is ongoing as it is for many aged care services due to shortages with staffing and that many staff are offered double shifts when shifts cannot be filled due to unplanned leave. The provider also advised that face to face training was impacted due to Covid-19 and that all staff had recently completed the mandatory manual handling onsite training. Performance development appraisals has fallen behind schedule and the provider has advised that a reminder has been sent to staff in relation to the timely completion of these.

I have considered the approved providers response and acknowledge that the provider has implemented actions and provided clarifying information to support their compliance with 7(3)(a) and 7(3)(c). I acknowledge that the provider is working toward the completion of the performance appraisals, however at the time of the response to the Assessment Team report, these appraisals had not been completed.

I therefore find that requirements 7(3)(a) and 7(3)(c) are Compliant and that 7(3)(e) is Non-compliant.

**Standard 8**

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| Organisational governance | |  |
| 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. | Non-compliant |

**Findings**

The Assessment Team found that the service did not adequately demonstrate that they were recognising and managing high impact and/or high prevalence risks associated with the care of consumers. The service did not sufficiently demonstrate effective risk identification and management in relation to these areas.

The Assessment Team reviewed the incident management system and the service’s SIRS register which identified deficits with the description of incidents not included and information relating to the medical attention or strategies to prevent reoccurrence not always accurate. Management advised that this information is in the incident management system located in the electronic file system. However, this was not evident for at least 1 SIRS report identified.

There were gaps observed in the effectiveness of the service’s identification and management of high impact high prevalence risks to consumers health safety and wellbeing in areas such as recognition and response to consumer deterioration, as well as management of wounds, falls and diabetes. Risk systems, policies and procedures were not always followed by staff resulting in a significant decline in the health safety and wellbeing of some consumers.

The approved provider responded to the Assessment Team’s report and advised that they have since updated the register to include additional fields for brief description of incident and contributing factors for investigation. Additional education will also be delivered to clinical staff on recognising and responding to clinical deterioration and emergency decision making guidelines to support their clinical decisions in the event of a consumer’s deterioration.

I have considered the approved providers response, however feel that it will take some time to reflect that the management of high impact and high prevalence risks is effectively demonstrated and that the risks are mitigated to prevent a reoccurrence.

I find that the approved provider is Non-compliant with this requirement.

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