Performance

Report

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| Name: | Southhaven Aged Care |
| Commission ID: | 2781 |
| Address: | 11 Queensbury Road, PADSTOW HEIGHTS, New South Wales, 2211 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 26 February 2024 to 27 February 2024 |
| Performance report date: | 13 April 2024 |
| Service included in this assessment: | Provider: 8845 IC (PADSTOW HEIGHTS) PTY LTD  Service: 1136 Southhaven Aged Care |

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 Southhaven Aged Care (**the service**) has been prepared by G-M. Cain, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# the provider’s response to the assessment team’s report received 19 March 2024.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 | 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 4** Services and supports for daily living | 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 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 performance report dated 8 November 2023 found the service non-compliant in Requirement 1(3)(a) with deficiencies relating to consumers’ being treated with respect, including respecting their privacy and ensuring that care was delivered in a timely manner.

The Assessment Contact Report contained information which identified the service demonstrated actions to improve its performance under this Requirement. Consumers and representatives confirmed consumers are treated with dignity and respect and feel valued, one consumer who was new to the service spoke of staff being amazing in helping her to settle to the service. Staff demonstrated understanding of individual consumers needs and preferences and observations showed staff engaging with consumers in a respectful manner. Staff have received elder abuse and dignity and respect training and updates, and the service has implemented strategies to ensure the sustainability of improvements including out of business hours monitoring of staff practices, and via feedback and complaints and surveys. It is my decision Requirement 1(3)(a) is Compliant.

# 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)(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 performance report dated 8 November 2023 found the service non-compliant in Requirement 2(3)(a), Requirement 2(3)(b) and Requirement 2(3)(e) with deficiencies relating to consumers’ care assessment and planning not consistently including the consideration of risks to the consumer’s health and well-being, or identifying and addressing consumer’s current needs, goals and preferences to inform safe and effective care delivery; consumer care and service plans were not consistently reviewed including when there was a change in the consumers health and/or wellbeing.

Consumers and representatives advised of improvements in relation to consumers’ clinical and personal care, including how the consumer’s care is planned for, with one consumer representative speaking of a partnership approach. Overall, care documentation demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care and actions taken where risks are identified. And while consumers prescribed anticoagulant medication did not have the risk of bleeding documented in the care plans to guide staff in monitoring for adverse effects of the medication, the approved providers response submission evidenced a review of all consumers prescribed anti-coagulant medication has been completed and this risk is reflected in care plans.

Care planning documents demonstrated consumers current needs, goals, and preferences were identified and addressed with strategies listed, including advance care and end of life planning. The service has provided education to staff and undertakes daily clinical huddles where consumers care (including current needs) is discussed. End of life planning conversations are held with consumers and their representatives at 4 monthly care plan reviews and case conferences.

Care documentation evidenced consumers care and services were reviewed for effectiveness every 4 months, or when consumers’ circumstances changed, such as after identified weight loss or a change in mobility for consumers. Improvement actions included implementation of 4 monthly care plan reviews, staff education, weekly review of chronic wounds by clinical management, and review of incidents by clinical management to ensure preventative measures are implemented. It is my decision Requirement 2(3)(a), Requirement 2(3)(b) and Requirement 2(3)(e) are 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)(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 |
| 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

The performance report dated 8 November 2023 found the service non-compliant in Requirement 3 (3)(a), Requirement 3 (3)(b) and Requirement 3(3)(e) and Requirement 3(3)(g).

Deficiencies related to:

* A lack of shared understanding of restrictive practices including the effective monitoring of consumers subject to restrictive practices, and the identification and management of pressure injuries.
* The inconsistent management of high impact or high prevalence risks including in relation to the management of pressure injuries, consumer risk/s associated with nutrition and weight loss; and incidents were not consistently recorded, investigated, or analysed to identify contributing factors and to support development of preventative measures.
* Consumer assessment, care planning processes and incident management did not effectively captured information to support the effective communication of consumer needs.
* Ineffective systems for minimising infection-related risks, including appropriate practices to prevent and control infection of practices to optimise antimicrobial use.

***In relation to Requirement 3(3)(a)***

Consumers and representatives consistently provided positive feedback about the clinical and personal care provided to consumers; and observations showed staff promptly responding to consumers’ care needs and requests for assistance. Staff demonstrated a shared understanding of the consumer’s clinical and personal care needs; and clinical documentation reflected consumers’ clinical needs were identified and responded to in a timely manner.

However, the Assessment Contact Report contained information relating to deficiencies in:

Restrictive Practices

Deficiencies included the management of consumers prescribed psychotropic medication including the identification of opportunities to reduce the use of psychotropic medications; and medications prescribed for end-of-life, being administered when the consumer was not receiving end-of-life care. This included:

* Two named consumers identified by the service as subject to chemical restrictive practices who did not have behaviour support plans which identified the behaviour of concern or strategies to be implemented prior to the administration of the psychotropic medication. For one of the named consumers, staff advised the consumer no longer presented with the changed behaviour, however, the service had not considered a review of the consumer with a view to ceasing the medication.
* For a third named consumer, medication prescribed for end-of-life care had been administered on 8 occasions in the previous 3 months, however, the consumer was not assessed as to be requiring end of life care.

I have considered this alongside the Approved Provider’s response and have come to a different view based on the submitted information which included (but not limited to) copies of consumer care documentation including charting, progress notes, assessments, and service documentation. The response submission identified:

* For the first named consumer, the psychotropic medication prescribed was commenced prior to entry to the service. I am satisfied that information contained in the response submission evidenced appropriate assessment of the named consumer was undertaken on entry to the service in collaboration with the named consumer’s representative; and a copy of the consumer's behaviour support plan reflects the documentation of the changed behaviours, triggers for the behaviours, and individualised strategies.
* For the second named consumer, the response submission evidenced regular review of the consumer’s prescribed psychotropic medications by the Geriatrician. A copy of the consumer's behaviour support plan reflects the documentation of the changed behaviours, triggers for the behaviours, and individualised strategies.
* For the third named consumer, information in the response submission evidenced the consumer was prescribed a medication in September 2023 with an indication for end-of-life pain. Progress notes dated 18 December 2023, identified the consumer experienced on going neck and shoulder pain and a review by the medical officer directed the use of the medication ‘as required’ in the management of the consumer’s pain. The response submission evidenced that the consumer’s medication chart has been reviewed and updated to reflect the indication for use of the psychotropic medication to include pain.
* In relation to the service’s actions to regularly review consumers prescribed psychotropic medications with a view to reducing where appropriate, the response submission provided information which demonstrated the service has implemented actions in this regard and evidenced since November 2023 a total of 26 psychotropic medications have been ceased (regular, as required and short course). I have placed weight on the evidence in relation to the second named consumer which identified this consumer’s prescribed psychotropic medication was regularly reviewed; and evidence under this and other requirements which identified education and training have been provided to the workforce in relation to restrictive practices, and the organisation has implemented a clinical audit program which is overseen by the clinical governance committee and reported to the governing body. Under Requirement 8(3)(e) the Assessment Contact Report identified additional work was still required by the service to demonstrate that legislative requirements for use of restrictive practices have been followed, however, lacked detail or examples of how the service does not comply with legislation in accordance with the Quality of Care Principles 2014.

Consumer monitoring

While overall, strategies to monitor consumers’ clinical care are implemented, the Assessment Contact Report contained information relating to the of monitoring of pain and fluid intake for one named consumer had not been commenced in a timely manner after the consumer had returned from hospital. The response submission provided information which identified the consumer has a history or congestive heart failure and self manages their fluid restriction and has been assessed to have the capacity to communicate needs (including pain). From the evidence before me, I am satisfied that the service management and monitored the named consumer, and the Assessment Contact Report lacked evidence is understand how the delay in monitoring resulted in unsafe or ineffective care.

Consumers and representatives provided positive feedback about care provided to consumers, and documentation demonstrated high-impact, high-prevalence risks, such as falls, weight loss and changes in consumers’ skin integrity were reviewed and monitored regularly, with risk mitigation strategies implemented.

Consumers and representatives spoke of improvements in relation to the information provided to them about care matters, with one consumer describing the service as now being very responsive. Observations of a shift handover showed staff receiving relevant information about consumers, including consumer’s condition, any changed needs, and requirements for monitoring over the next shift. Documentation demonstrated information about consumers was documented and shared as appropriate.

The service demonstrated processes in relation to infection prevention and appropriate antibiotic use, including policies and procedures to guide staff and the training of an infection prevention control lead (IPC lead). Staff described how they would minimise infection related risks and promote appropriate antibiotic prescribing. The service was observed to have implemented infection control measures such as hand hygiene stations throughout the service, and staff were observed to following infection control practices.

Improvement actions included (but were not limited to):

* Education for the workforce in relation to restrictive practices, high impact and high prevalence risks, incident management and infection prevention and control principles.
* Review (and reassessment as required) of consumers to identify, monitor and manage consumers’ high impact and high prevalence risks, including the implementation of a risk register.
* Increase clinical oversight by clinical management including daily review of progress notes and observations of staff practices.

It is my decision Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(e) and Requirement 3(3)(g) are Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The performance report dated 8 November 2023 found the service non-compliant in Requirement 4(3)(d), Requirement 4(3)(e) and Requirement 4(3)(f) with deficiencies related to consumer’s lifestyle needs not consistently being understood by staff and information in care documentation not reflecting how the service supports each consumer’s interests; referrals for consumers were not timely and external provider recommendations not consistently implemented; and a lack of suitable meal options and snacks being readily available.

Consumers and representatives spoke of care being provided by staff that were aware of consumers needs and preferences. Staff described the service’s processes for updating and communicating information, including when there is a change in a consumer’s condition, needs and preferences.

The service demonstrated timely and appropriate referrals to individuals, and other organisations and providers of other care and services. Consumer representatives and staff provided examples of referrals made for individual consumers’, and a review of care documentation identified consumer care plans were reviewed with recommendations implemented.

Consumers provided examples of how the service ensured meals are varied, suitable quality and quantity. Review of the service’s national menu 2023 identified a review by the dietitian in October 2023 and recommendations were implemented in alignment with the review including additions to the menus to ensure consumers’ nutritional requirements were met.

Improvement actions included (but were not limited to):

* Multidisciplinary review of consumers lifestyle assessments and re-education for staff on consumers lifestyle needs and referral processes.
* Review of consumers progress notes daily by care management to ensure timely action of recommendations including referrals.
* Menu review to ensure inclusion of dietitian recommendations, and management presence at mealtimes to oversee and support the dining experience.

It is my decision that Requirement 4(3)(d), Requirement 4(3)(e) and Requirement 4(3)(f) are Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The performance report dated 8 November 2023 found the service non-compliant in Requirement 7(3)(b), Requirement 7(3)(c) and Requirement 7(3)(d) with deficiencies related to staff not always interaction in a kind and respectful manner, staff not having the knowledge and skills to perform their roles specifically in supporting consumers who are living with dementia; and effectiveness of training for staff.

Consumers and representatives said staff were kind, caring, and respectful of consumers’ and observations showed staff interacting with consumers in a kind, gentle and caring manner.

Consumers and representatives spoke of staff knowing what they are doing and provided examples of how staff demonstrated this in care and service delivery. Staff described training that had been provided by the service, including assessment of competence in a number of areas including medication management and infection management and prevention. Review of documentation demonstrated the completion of staff training and competency assessments.

Management and staff explained how the workforce was trained and equipped to deliver the outcomes required by these standards. Annual mandatory training for staff includes infection control, Serious Incident Response Scheme, and fire safety, and documentation demonstrated staff were supported through induction processes, mandatory training and other educational programs. The service has engaged with staff via a survey to seek feedback and suggestions for learning and development in the coming 12 months. In relation to performance management, interviews with management and review of service documentation identified the service implemented a process when managing areas of poor performance.

Improvement actions included (but were not limited to):

* Staff education on consumer dignity and respect; and the implementation of performance management processes for staff who do not practice in alignment with these principles.
* The development and implementation of a staff training program that includes training for staff in dementia and behaviour management.
* Implementation of processes to monitor and track the completion of mandatory training of staff, with additional training and support provided through one-to-one meetings to understand staff’s needs.
* Increased presence and oversight by management in monitoring of staff practices and interactions with consumers.

It is my decision that Requirement 7(3)(b), Requirement 7(3)(c) and Requirement 7(3)(d) are 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

The performance report dated 8 November 2023 found the service non-compliant in Requirement 8(3)(b), Requirement 8(3)(c) and Requirement 8(3)(d) and Requirement 8(3)(e) with deficiencies related to systems to ensure a culture of safe and quality care and services including mechanisms to ensure the governing body is accountable for their delivery; the organisation did not demonstrate effective organisation wide governance systems in place including risk management and clinical governance.

The organisation implemented systems and processes to monitor the performance of the service, and to be accountable for the delivery of safe, inclusive, quality care and services. Management explained how the organisation had recruited staff including state management and a quality advisor who maintain oversight and monitoring of improvements, key clinical performance indicators and the reporting of these through the organisation to the governing body.

Organisation wide governance systems were effectively supported by policies, procedures, training, audits and reporting mechanisms, relating to: information management, continuous improvement, financial governance, workforce governance, regulatory compliance, feedback and complaints. For example:

* The organisation had processes for workforce management including staff performance management, recruitment, and education; and the service engages with staff via a survey to seek feedback and suggestions for learning and development opportunities.

The risk management framework demonstrated effective systems and practices were in place to manage high-impact, high-prevalence risks associated with the care of consumers, identifying, and responding to abuse and neglect, supporting consumers to live the best life they can, managing and preventing incidents. The service reviewed all consumers to identify individual high impact and high prevalence risk/s, and this is documented in a risk register. Education has been provided to staff in high impact or high prevalence risks and incident management, and a review of incident reports identified overall incidents are thoroughly investigated to identify root causes and actions taken in response including the implementation of measures to prevent future incidents.

The service had implemented a clinical governance framework providing an overarching monitoring system for clinical care. The framework addressed the key clinical governance areas of antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure. The service is supported by a suite of updated clinical policies and procedures to guide staff practice, and staff demonstrated a shared understanding of these policies and could describe how they apply these as relevant to their roles.

Improvement actions included (but were not limited to):

* The review and updating of the organisations policies and procedures to ensure alignment with best practice, with new policies and procedures requiring approval by executive leadership.
* In relation to organisational systems, improvements include investigation and root cause analysis to identifying and implement risk minimisation strategies; implementation of a comprehensive incident management framework (dated 13 February 2024) which includes process and guidance for the escalation of incidents, timeframes for escalation and finalising of incidents including notifications under the Serious Incident Response Scheme.
* Implementation of a clinical audit program, which includes the completion of regular clinical audits at the service by a member of the organisation’s clinical governance committee.
* The development and implementation of a staff training program that includes training for staff in consumer dignity and respect, dementia, and behaviour management, including processes to monitor and track the completion of mandatory training of staff.
* Review the organisation’s clinical governance framework, including review and update of key clinical policies and procedures.

It is my decision that Requirement 8(3)(b), Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) are Compliant.

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