Performance

Report

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| Name of service: | St Andrew's Village Ballina |
| Service address: | 59 Bentinck Street BALLINA NSW 2478 |
| Commission ID: | 2709 |
| Approved provider: | St Andrew's Village Ballina Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 May 2023 to 10 May 2023 |
| Performance report date: | 19 June 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for St Andrew's Village Ballina (**the service**) has been prepared by Stewart Brumm, 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 2 June 2023.
* Information provided by the intake, complaints, and resolution group of the Aged Care Quality and Safety Commission.

# 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 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 | **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 |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

These requirements were previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

The Assessment Team provided information that consumers stated they felt respected and treated with dignity as there have been no delayed response times in the event of an incident due to a malfunctioning call bell system. Consumers described how staff knock before entering their rooms and respond in a timely manner when they activate their call bell or sensor mats alert. Consumers advised the service had upgraded the call bell system in December 2022 which is working much better, and staff usually respond within a 10-minute timeframe.

The Approved Provider was able to demonstrate appropriate risk assessments have been conducted on most consumers, and dignity of risk discussions have occurred with consumers/representatives who wish to take risks and have been documented.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including installation of a new call bell system and providing additional training to staff on dignity of risk for consumers. The Assessment Team verified these improvements have occurred and are sustainable.

Based on the information provided by the Assessment Team, I am persuaded by the consumer feedback and the demonstrated improvements completed.

I find these Requirements are compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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

This Requirement was previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

The Assessment Team provided information that care plans are being reviewed 3 monthly as per the care plan schedule developed by the care planning co-ordinator. These are displayed in each nurses station for the registered nurse to refer to as well as alerts being sent through the electronic care management system. A dedicated Registered Nurse has been appointed to ensure all care plans have been reviewed and are up to date.

The Assessment Team reviewed 13 care plans, and all had been reviewed in the last 3 months as per the schedule or updated if there were any changes in the consumer’s condition.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including allocation of a dedicated Registered Nurse to manage care plan reviews, the establishment of a review schedule and provided education to staff on completing care plan reviews.

However, I note the Assessment Team identified that for 6 of the 13 care plans reviewed, there were deficits in the information recorded. The Assessment Team did not identify any negative impact on consumers with the care plan errors. The Approved Provider response did not address this ongoing deficit. The Approved Provider is encouraged to review the monitoring processes to ensure information remains current.

In forming my view of compliance, I accept the improvement actions implemented, however note there is an ongoing requirement to monitor the effectiveness of the improvements. I am satisfied that the care plans are now being reviewed. In relation to the effectiveness of the care plans to guide staff practice, whilst the Assessment Team identified ongoing defects in accuracy of information, I am persuaded that there is no identified impact on the consumers.

I find this Requirement 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 |

Findings

These requirements were previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

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

The Assessment Team provided information that the Approved Provider was able to demonstrate an understanding of the types of restrictive practice and the legislative requirements related to the use of chemical restrictive practice. The Approved Provider has a psychotropic register as part of their medication management system which is automatically populated when the medical officer prescribes psychotropic medication and completes the chemical restrictive practice form in the system.

However, the Assessment Team noted that while the psychotropic register is generated from the medication management system, some Medical Officers do not correctly identify psychotropic medications as chemical restrictive practice. The Approved Provider did not have consent or authorisation for those consumers identified by the medical officers as receiving chemical restrictive practice but did have behaviour support plans in place.

The Approved Provider provided a response to the Assessment Team report that included a copy of the psychotropic register as well copies of consents for use of restrictive practice and behaviours support plans for 14 consumers. I am satisfied that verbal consent is being obtained for the use of chemical restraint and behaviour support plans are produced.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including a review of the restrictive practice policy and implemented behaviours support plans for consumers subject to restraint.

I have considered the information provided by the Assessment Team as well as the Approved Provider response and I am satisfied the Approved Provider has a process for obtaining consent for the use of the restrictive practice and for the development of behaviour support plans.

I find this requirement is compliant.

**In relation to Requirement 3(3)(b):**

The Assessment Team provided information that the Approved Provider is able to identify which consumers are subject to chemical restrictive practice and have a monitoring system for consumers receiving psychotropic medications to ensure their medication is reviewed regularly for associated risks. The service has a psychotropic register which identifies those consumers receiving chemical restrictive practice and is reviewed 3 monthly by the clinical staff and medical officer when reviewing the restrictive practice authorisation form. Clinical indicators including restrictive practices are reviewed monthly, any trends identified, and a report presented to the board.

The Approved Provider provided a response to the Assessment Team report that included a copy of the psychotropic register as well copies of consents for use of restrictive practice and behaviours support plans for 14 consumers. I am satisfied that verbal consent is being obtained for the use of chemical restraint and behaviour support plans are produced.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including a review of the restrictive practice policy, and implemented behaviours support plans for consumers subject to restraint.

I have considered the information provided by the Assessment Team as well as the Approved Provider response and I am satisfied the Approved Provider has a process for obtaining consent for the use of the restrictive practice and for the development of behaviour support plans.

I find this requirement is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

This requirement was previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

The Assessment Team provided information that the vast majority of consumers interviewed expressed satisfaction with the variety and quantity of food and beverages being provided at the service and stated there are sufficiently varied choices for each daily meal. Consumers are able to request different meals if they dislike what is offered. Management described how consumers are involved in designing the menu through food focus group meetings and consumer meetings. Consumers’ care plan documents, including dietary requirements and preferences, are consistent with the information recorded by catering staff and aligns with consumer and feedback.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including contracting a catering company to manage the kitchen, catering staff and meals. Catering at the service is overseen by the onsite contracted catering coordinator, ensuring consumer dietary requirements and preferences are met.

Based on the information provided by the Assessment Team, I am persuaded by the consumer feedback and the demonstrated improvements completed.

I find this Requirement is compliant.

# 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

These requirements were previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

The Assessment Team provided information that the Approved Provider enables consumers to move around freely indoors and outdoors. Consumers and representatives expressed satisfaction with the accessibility of the service. Staff were observed providing mobility assistance to consumers throughout the service.

The service has a new call bell system. Consumers expressed satisfaction with the functionality of the new call bell system. The maintenance manager provided the preventative maintenance schedule for the call bell system. The Assessment Team observed the call bell system functioning effectively.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including ensuring external doors need to be open for free movement of consumers. The service demonstrated during the Assessment Contact consumers egress via external doors is enabled via keypad activation, with codes displayed above the keypads to enable free movement. A new call bell system has also been installed.

Based on the information provided by the Assessment Team, I am persuaded by the consumer feedback, observations by the Assessment Team and the demonstrated improvements completed.

I find these Requirements are compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

This requirement was previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

The Assessment Team provided information that consumers sampled expressed satisfaction with the service’s response to their feedback and complaints. The Approved Providers’ feedback register evidenced feedback and complaints are actioned in an appropriate and timely manner.

Management and staff demonstrated a shared understanding of the process followed when feedback or a complaint is received. Staff are guided by the organisation’s Complaints Handling Guide, which outlines a 14-day complaint resolution policy, in conjunction with the Feedback Policy and Procedures.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including the Executive Assistant records all feedback and complaints as received, and feedback is assigned to the relevant executive manager to action. Feedback and Complaints is listed as a standing agenda item for weekly executive team meetings.

Based on the information provided by the Assessment Team, I am persuaded by the consumer feedback, management and staff understanding of the system and the demonstrated improvements completed.

I find this Requirement is 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

These requirements were previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

In relation to Requirement 7(3)(a):

The Assessment Team provided information that most consumers said staff provide timely and effective care and services. Staff expressed that there is enough staff to provide quality care and services, and confirmed the call bell system was functional. A review of the call bell reports demonstrated most call bells are responded to within 10 minutes, and the Assessment Team observed staff responding to requests for assistance in a timely manner.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including the installing a new call bell system and undertaking a recruitment drive to ensure sufficient staffing levels.

Based on the information provided by the Assessment Team, I am persuaded by the consumer and staff feedback and demonstrated improvements completed.

I find this Requirement is compliant.

In relation to Requirement 7(3)(c):

The Assessment Team provided information that while most consumers expressed that staff are competent in their roles, the Assessment Team identified a number of incidents which were attributed to poor manual handling techniques and medication errors. A review of the service’s training records showed that not all staff have completed the annual manual handling training or the medication competency assessment.

In response to this feedback, the Approved Providers’ Educator advised that while many staff have received manual handling training, manual handling competency assessments have not been conducted as the assessments are still under development. They also said that the medication competency assessments have not been completed as the service has been unable to secure qualified staff or external organisations to conduct the training and assessment.

The Approved Provider provided a response that included planned actions to address the training deficits as well as a competency assessment schedules. The Approved Provider has a registered nurse contracted to conduct medication competency assessments. The enrolled nurse assessors will conduct some enrolled nurse and all care staff medication competency assessments and will conduct all manual handling competency assessments. The provided schedule indicates the process has commenced and due to completion by the end of June 2023.

Based on the information provided by the Approved Provider, I am persuaded that the Approved Provider has taken corrective action to address the deficits identified by the Assessment Team.

I find this Requirement is compliant.

In relation to Requirement 7(3)(d):

The Assessment Team provided information that most consumers considered that the workforce provide quality care and services due to being well trained. Most staff interviewed said they have either participated in or are scheduled to complete the annual mandatory training and feel supported by management to deliver the outcomes requested by these standards. A review of the services annual mandatory training register indicates that staff have either completed the training or are scheduled to complete the training in May 2023

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including development and implementation of a mandatory training schedule.

Based on the information provided by the Assessment Team, I am persuaded by the consumer and staff feedback and demonstrated improvements completed.

I find this Requirement is compliant.

In relation to Requirement 7(3)(e):

The Assessment Team provided information that the Approved Provider was unable to demonstrate regular performance monitoring and review of staff capabilities. At the time of the Assessment Contact documentation provided evidenced 50% of staff annual performance appraisals were overdue. Management confirmed that staff performance appraisals were overdue and did not comment on the reason they were overdue.

The Assessment Team identified that a number of medication incidents had occurred at the service since January 2023 and requested evidence demonstrating that the performance of the staff members involved in the incidents had been reviewed and monitored. The Facility Manager Clinical said that staff involved in the incidents had not participated in any formal performance management activities and there was no documented evidence that staff performance is reviewed and monitored following an incident.

The Approved Provider provided a response that included clarifying information as well as a copy of the performance review schedule. The Approved Provider identified that the majority of the performance appraisals had been completed and an error in the recording of completed appraisals had resulted in the deficit in information presented to the Assessment Team. The performance appraisals schedule identified that the vast majority of staff have completed or have planned an annual performance appraisal.

I note that there is a process to monitor staff performance on an annual basis. Whilst the Approved Provider did not address the monitoring of staff performance post incidents occurring in response to the information raised in the Assessment Team report, I note from information provided by the Intake, Complaints and Resolution Group within the Commission that the Approved Provider does take action to address staff knowledge post incident. This included following a suspected medication incident at a consumers end of life, that all registered and enrolled nursing staff are undertaking medication competency assessments. The Approved Provider also reported staff to the relevant health authority.

I find on balance of the information provided that the Approved Provider has processes for the regular assessment, monitoring and review of the performance of each member of the workforce.

I find this Requirement is 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

These requirements were previously found non-compliant following the Site Audit conducted from 26 to 28 July 2022.

In relation to Requirement 8(3)(b):

The Assessment Team provided information that management and staff said the introduction of a new electronic care management system has improved data collection and the data, along with clinical and serious incidents, are reviewed fortnightly by the clinical team and monthly by the Board to identify risks and risk mitigation strategies. Through a review documentation and clinical staff interviews, the Assessment Team confirmed that clinical data is reviewed at clinical meetings and reports are submitted to the Board.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including education for staff on the serious incident response scheme, review of policies and establish a registered for reporting to the serious incident response scheme.

Based on the information provided by the Assessment Team, I am persuaded by the staff feedback and demonstrated improvements completed.

I find this Requirement is compliant.

In relation to Requirement 8(3)(c):

The Assessment Team provided information that while the Approved Provider was able to demonstrate that it had taken effective actions to address the issues surrounding information management and feedback and complaints, the service was unable to unable to demonstrate effective governance systems to ensure the workforce is competent and have the required skills and knowledge to perform their roles.

The Approved Provider provided a response to the Assessment Team report that included clarifying information as well as a competency assessment schedule and performance appraisal schedule. I have considered the additional information provided and I am satisfied that the Approved Provider has planned and is implementing corrective actions to address the deficits identified by the Assessment Team.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including introduction of a new electronic care management system with accompanying staff training. Staff training has been arranged and is being provided in relation to manual handling, medication management and the serious incident response scheme. Processes have been revised for the management of complaints, with complaints a standing agenda item for the executive team.

Clinical and care staff confirmed that information about consumer’s needs and preferences are communicated during handover and via the electronic care management system to improve effectiveness and consistency of care.

Based on the information provided by the Assessment Team and Approved Provider, I am persuaded by the staff feedback and demonstrated improvements completed.

I find this Requirement is compliant.

In relation to Requirement 8(3)(d):

The Assessment Team provided information that a review of consumer care documentation indicates consumers with identified personal and clinical risks have appropriate risk assessments and dignity of risk documentation in place. Staff had a shared understanding of serious incidents and said they feel encouraged and supported to report serious incidents. The Approved Providers’ incident register demonstrated that incidents are documented and analysed to improve care and services, and the service’s training schedules confirmed staff are trained in incident reporting and serious incident response scheme.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including completing risk assessments for consumers with identified personal or clinical risks. Education for staff on dignity of risk and the serious incident response scheme has been provided.

Based on the information provided by the Assessment Team, I am persuaded by Approved Providers demonstration of processes and demonstrated improvements completed.

I find this Requirement is compliant.

In relation to Requirement 8(3)(e):

The Assessment Team provided information that the Approved Provider was able to demonstrate an effective overarching clinical governance framework and policies to guide staff in provision of safe care and outlines core elements of restrictive practices and open disclosure.

Staff demonstrated a shared understanding of how the Approved Provider practices open disclosure, including being open, transparent, and apologising when things go wrong. They also demonstrated understanding of minimises the use of restraint, including the use of behaviour support plans to reduce or eliminate the inappropriate use of restrictive practices and ensuring they are used a last resort.

The Approved Provider undertook a range of improvement activities to address the previous non-compliance including implementation of a revised clinical governance framework, updating of policies and procedures, and updating roles and responsibilities of staff.

Based on the information provided by the Assessment Team, I am persuaded by Approved Providers demonstration of processes and demonstrated improvements completed.

I find this Requirement is compliant.

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