Performance

Report

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| Name: | St George's Care Centre |
| Commission ID: | 7257 |
| Address: | 2 Essex Street, BAYSWATER, Western Australia, 6053 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 10 October 2024 |
| Performance report date: | 6 November 2024 |
| Service included in this assessment: | Provider: 701 Amana Living Incorporated  Service: 5298 St George's Care Centre |

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 George's Care Centre (**the service**) has been prepared by Katherine Richards, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management, and others; and
* the performance report dated 19 April 2024, following a site audit undertaken from 20 February 2024 to 23 February 2024.

The provider submitted an email on 5 November 2024 stating they did not wish to provide a formal response.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not fully assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not fully assessed** |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 4** Services and supports for daily living | **Not fully assessed** |
| **Standard 6** Feedback and complaints | **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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |

Findings

Requirement 1(3)(b) was found non-compliant following an assessment contact undertaken in February 2024 as consumer culture had not been sufficiently considered within care planning documentation, and staff did not always deliver care in a way that respected or considered the cultural background of consumers. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, updating entry process requirements to capture cultural, spiritual, and social needs; piloting a new assessment framework; working with local communities to support cultural needs; and providing cultural awareness training for staff.

During the assessment contact undertaken in October 2024, consumers gave examples of how the service accommodated their cultural needs and preferences to ensure provision of culturally safe care. Staff said they had received training in provision of culturally safe care and demonstrated awareness of cultural needs of consumers and how this was used to inform care delivery. Care planning documentation included details of the social, spiritual, and cultural backgrounds of consumers and actions to meet specific cultural needs.

Based on the evidence before me, I find requirement 1(3)(b) in Standard 1 Consumer dignity and choice compliant.

# 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 |

Findings

Requirement 2(3)(b) was found non-compliant following an assessment contact undertaken in February 2024 as consumer preferences were not captured, and discussions relating to end of life care were not undertaken in a timely manner. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, capturing needs, goals, preferences, and commencing advance care planning within entry assessment and planning.

During the assessment contact undertaken in October 2024, care planning documentation evidenced needs and preferences were captured and aligned with consumer feedback. A representative verified involvement in discussions on advance care planning. A monthly care plan audit and consumer review was implemented and undertaken to ensure assessment and planning accurately reflected consumers’ needs, goals, and preferences.

Based on the evidence before me, I find requirement 2(3)(b) 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(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) were found non-compliant following an assessment contact undertaken in February 2024. Clinical care of urinary catheters was not provided in line with best practice guidance or directives, and personal care was not always delivered in line with consumer preferences. Risks relating to wound care, use of psychotropic medication, and choking were not consistently recognised and managed. Deterioration in consumer condition, capacity, or function was not recognised in relation to weight loss and diabetes management. Staff did not demonstrate a shared understanding of documentation practices to ensure effective communication about consumer condition, needs, or preferences.

In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, providing staff training; reviewing assessment and planning outcomes of consumers; enhanced monitoring and auditing by senior clinical staff; review of high impact and high prevalence risks within multidisciplinary team meetings; and improved communication processes.

During the assessment contact undertaken in October 2024, care planning documentation evidenced clinical care was provided in line with best practice guidelines and included tailored responses for management of changed behaviours and urinary catheters. Staff gave examples of how they provided care consistent with consumer needs and preferences. Most consumers and representatives said they felt safe and comfortable with the provided care. In response to the concerns of one representative, management explained enhancements they would make to the monitoring processes already undertaken to ensure pain was recognised and comfort managed.

High impact or high prevalence risks of consumers and management pathways were known by staff. Care planning documentation evidenced regular review of wounds and pain, and consumers at risk of pressure injury had preventative measures implemented. Management detailed the auditing process introduced to identify, track, and analyse consumer risks with mitigating interventions developed and ongoing reviews within multidisciplinary team meetings. Monitoring and reviews were undertaken following falls in line with policies and procedures.

Staff articulated their role and responsibility to identify and report signs of deterioration of consumer condition, with ongoing education to reinforce organisational policies. Care planning documentation demonstrated change in consumer condition was identified and responded to, with oversight by senior clinical staff. Consumers and representatives expressed confidence staff could identify a change in consumer health, providing examples of when this had happened and responsive actions.

Consumers and representatives reported information about consumer needs and preferences was effectively communicated between staff, ensuring continuity of care. Staff explained available written and verbal methods of sharing information about consumers. The electronic care management system included alerts to inform of changes to consumer condition, needs, or preferences, and other communication methods included handover, a communication book, whiteboards, emails, and meetings. Care planning documentation provided detailed information to support safe and effective delivery of care, with monitoring and oversight to ensure timely updates.

Based on the evidence before me, I find requirements 3(3)(a), 3(3)(b), 3(3)(d), and 3(3)(e) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirements 4(3)(c) and 4(3)(f) were found non-compliant following an assessment contact undertaken in February 2024 as consumers were not supported to do things of interest or have social relationships of meaning, and consumers reported dissatisfaction with the quality and quantity of provided meals with limited or ineffective improvements made in response to feedback or complaints. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, developing focus groups and seeking consumer feedback through a range of pathways; creating referrals for occupational therapy or external providers for consumers who do not participate in group activities; providing staff training; adding additional meal and snack options; holding alternate frozen meals for consumers unhappy with selections; and employing a dietitian.

During the assessment contact undertaken in October 2024, care planning documentation recorded consumer participation in group and individual activities. Consumers and representatives gave positive feedback on activities, including new events which included invitations for family members. The monthly activity planner included a range of activities tailored to meet different preferences of consumers.

Consumers and representatives were generally satisfied with the quality and variety of provided meals or could describe arrangements made to accommodate their preferences. A snack trolley and vending machine were available to consumers with a variety of options available. Consumers were not being presented with sample plates to inform meal choices, despite this being outlined within improvement actions, although staff were observed to be verbally describing available choices. Staff confirmed they monitored consumption of meals, and if the consumer wasn’t eating an alternate was offered or it was escalated to clinical staff.

Based on the evidence before me, I find requirements 4(3)(c) and 4(3)(f) in Standard 4 Services and supports for daily living 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

Requirement 6(3)(c) was found non-compliant following an assessment contact undertaken in February 2024 as feedback was not consistently recorded, actioned, or responded to, and the service could not demonstrate use of an open disclosure approach in response to incidents. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, seeking consumer feedback routinely within assessment and planning review processes; and providing training to staff.

During the assessment contact undertaken in October 2024, consumers and representatives said they received appropriate responses and resolutions to complaints, although one said they received timelier responses when complaints were in writing rather than raised verbally. Staff said they were encouraged to acknowledge mistakes and demonstrated awareness of the open disclosure principles used in response. Management described how feedback and complaints were recorded and managed in line with policies and procedures. Training records evidenced staff received education in application of open disclosure as part of incident management processes.

Based on the evidence before me, I find requirement 6(3)(c) in Standard 6 Feedback and complaints 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Requirements 7(3)(b) and 7(3)(d) were found non-compliant following an assessment contact undertaken in February 2024 as consumers reported staff did not always treat them with respect and kindness, and staff did not always have the knowledge to deliver safe and effective clinical care or investigate and escalate incidents. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, undertaking investigation and follow up on consumer concerns; ensuring staff undertook mandatory training; and providing education on identified deficiencies relating to clinical care and incident management.

During the assessment contact undertaken in October 2024, consumers and representatives described staff interactions to be kind and caring. Staff gave examples of how they ensured consumers were treated with kindness and respect. Management explained staff were required to adhere to organisational policies, procedures, and values to ensure provision of culturally appropriate person-centred care and services.

Management described recruitment and onboarding processes for new staff. Staff explained they could request additional training if required, and ensured they completed all mandatory training required for their role. In coming to my decision, I have also considered evidence of improvements in delivery of clinical care as outlined in Standards 2 and 3.

Based on the evidence before me, I find requirements 7(3)(b) and 7(3)(d) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| 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

Requirement 8(3)(e) was found non-compliant following an assessment contact undertaken in February 2024 as the clinical governance framework had not ensured processes and policies were adhered to during delivery of clinical care, antimicrobial stewardship practices were not implemented in relation to antibiotic therapy use and monitoring, and staff did not demonstrate a shared knowledge of open disclosure processes. Governance systems did not ensure effective identification and application of restrictive practices. In response to the non-compliance the provider has implemented a range of improvements, including, but not limited to, reviewing incident reporting, investigation, and management practices including use of open disclosure; provision of staff training relating to restrictive practices; undertaking ongoing reviews of psychotropic medication use to ensure chemical restraint use was appropriately used.

During the assessment contact undertaken in October 2024, documentation evidenced data was collected and analysed to monitor provision of clinical care and inform improvements. The clinical governance framework had been updated and included strengthened policies, procedures, and staff training on key clinical areas. Monitoring processes were reflected within clinical and care committee meetings, with management also able to explain monitoring and review of clinical indicators and performance. In coming to my decision, I have also considered evidence of improvements in delivery of clinical care as outlined in Standards 2 and 3.

Based on the evidence before me, I find requirement 8(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)