Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | St Nicholas Aged Care |
| Service address: | 19 Hampstead Road HIGHGATE HILL QLD 4101 |
| Commission ID: | 5995 |
| Approved provider: | Greek Ladies Philoptochos Society of St George Brisbane |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 May 2023 to 31 May 2023 |
| Performance report date: | 29 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 Nicholas Aged Care (**the service**) has been prepared by T Wurf, 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, and
* the Performance Report dated 12 October 2022 for the site audit undertaken from 16 to 19 August 2022 where 18 requirements of the Quality Standards were found non-compliant.

# Assessment summary

|  |  |
| --- | --- |
| 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

|  |  |  |
| --- | --- | --- |
| 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)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Performance Report dated 12 October 2022 found the service non-compliant with requirements 1(3)(a) and 1(3)(f) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* Consumers were not consistently treated with dignity and respect.
* Consumer’s privacy due to four-bedded rooms with only curtains and no doors, and aspects of care or conversations seen or heard through the curtains.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* The service no longer uses mechanical restrictive practices.
* Increased staffing which improved the availability of staff to attend to consumers.
* Staff training on restrictive practices, dignity and respect, privacy, and bedside manner.
* Providing alternative private spaces for consumers to have conversations, private gatherings or care consultations.
* Consulted with consumers who reside in shared rooms about privacy requirements. No concerns were reported and consumers were aware of alternate rooms they could access.

Consumers and representatives reported that staff treat consumers with dignity and respect, provide respectful care and services, and respond to requests for assistance.

The Assessment Team observed staff attending promptly to consumers’ calls for assistance and engaging with consumers in a respectful and dignified manner. They also observed consumers calm and seated in the dining room being assisted with meals.

Consumers and representatives said consumers’ privacy is respected and the confidentiality of their personal information is maintained. Consumers who reside in four-bedded rooms said they like the shared room for the company. Staff described various ways they ensure a consumer’s privacy and confidentiality are upheld.

The Assessment Team observed staff maintaining consumer privacy by knocking on doors and waiting for a response before entering rooms. Curtains were drawn in shared rooms when staff were providing care or if consumers were resting.

Based on the findings in the Assessment Contact – Site Report and improvements made by the service, I am satisfied the deficiencies have been remediated and consumers are treated with dignity and respect and their privacy is maintained. Therefore, it is my decision that these requirements are compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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)(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 12 October 2022 found the service non-compliant with requirements 2(3)(a) and 2(3)(e) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* Assessment and planning, and consideration of risks to consumers’ health and well-being in relation to changes in consumers’ behaviours, changes in sleep patterns, and falls management.
* Review of care and services when incidents, including in relation to changes in consumers’ behaviours, post fall management and changes in consumers’ sleep patterns.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* Daily monitoring of consumers’ care notes and reporting of changes to a consumer’s health or condition.
* Monthly reporting to the Board on clinical indicators and actions to minimise risk to consumers.
* Staff training and education in behaviour support management, falls prevention, and high-impact and high-prevalence risks.

The Assessment Contact – Site Report identified that care documentation demonstrated assessment, planning and individualised strategies for consumers at risk of falling, changes in behaviours and changes in sleep patterns. Consumers were satisfied with the assessment and planning of their care in these areas. Staff interviewed by the Assessment Team could describe the strategies for individual consumers. The Assessment Team observed some of these strategies to be in place, for example, consumers’ rooms to be free of clutter and other falls prevention strategies. Staff described how they escalate concerns or changes in consumers to the clinical manager or medical officer for review.

Staff interviews and a review of consumers’ care documentation confirmed consumers’ care and services were reviewed regularly and that consumers’ care plans were updated when needs change.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies and undertakes effective assessment, planning and review of consumers’ care and services. Therefore, it is my decision that these requirements are compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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)(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 12 October 2022 found the service non-compliant with requirements 3(3)(a), 3(3)(b) and 3(3)(g) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* Personal and clinical care provided to consumers and management of high impact high prevalence risks. This included deficits in the management of falls, behaviours, suicidal ideations, and the use of chemical and mechanical restrictive practices in line with the legislative requirements.
* Infection-related risks were not minimised in relation to catheter care, cleaning of shared consumer equipment, and cleaning consumers’ bathrooms and utility rooms.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* Staff training and education on:
  + the electronic care management system, and
  + various topics related to care and risk, including restrictive practices, falls, incidents, risk assessment, catheter care
* Processes to monitor, trend and report monthly to the Board on high-impact and high-prevalence risks.
* Restrictive practices:
  + The highchairs identified in the previous site audit were removed and replaced with pressure-relieving reclining chairs, which are only used by consumers assessed as not independently mobile.
  + Clinical monitoring of the use of prescribed psychotropic medication to ensure it is not administered for changes in consumers’ behaviour.
* The service’s electronic care management system has clinical pathways, including for catheter care. The service changed its type of catheters and cleaning schedule.
* New staff receive orientation training on cleaning and cleaning wipes are attached to equipment, and are located throughout the service.

The Assessment Contact – Site Report identified that consumers were satisfied that the care they receive meets their needs. They said staff were responsive to their needs and know them well. Consumers said cleaning has improved and bathrooms and shared equipment are cleaned regularly.

The Assessment Team reviewed consumers’ care documentation and found:

* no consumers were subject to mechanical or chemical restrictive practices - mobile consumers are not subject to a mechanical restrictive practice
* consumers with changes in behaviours were managed effectively
* consumers who fall were reviewed for changes in strategies to prevent future falls occurring in an appropriate timeframe. Immediate post fall management was completed by registered staff in accordance with the service’s falls prevention policy
* super pubic catheter care was consistently completed and documented, staff knew how to complete catheter care for consumers, and consumers were satisfied with how their catheter was managed,
* a consumer who was having negative thoughts reflected review by a medical officer and geriatrician and their behavioural support plan, and
* regular assessment, planning, monitoring, and review of consumers’ care, and the involvement of medical officers, allied health and other specialists where required.

Staff could describe consumers’ individual needs and preferences and how these are managed in line with their care and service plan. They confirmed they had attended education and training on various topics. The service completes fortnightly audits to monitor the service’s infection prevention and control strategies.

The Assessment Team observed:

* staff assisting consumers sitting in reclining pressure relieving chairs
* shared consumer equipment, consumers’ bathrooms and the utility rooms and noted they were consistently clean, and
* staff spending one on one time with consumers.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies in relation to the delivery of personal and clinical care, high impact and high prevalence risks, and infection-related risks. Therefore, it is my decision that these requirements are compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |

Findings

The Performance Report dated 12 October 2022 found the service non-compliant with requirement 4(3)(b) following a site audit undertaken from 16 to 19 August 2022. Consumers’ emotional and psychological well-being were not supported.

The Assessment Contact – Site Report identified evidence that the service implemented a process to monitor consumers’ care documentation daily to ensure individualised support plans and strategies are completed, and to identify changes in consumers’ emotional and psychological requirements, which may trigger a clinical review or referral to a medical officer or community psychological services.

Consumers’ care documentation demonstrated emotional and psychological needs were assessed and individualised strategies to support emotional and psychological wellbeing were in place, including for consumers with dementia or mental health. Where required, a medical officer reviewed consumers and provided counselling or referrals to specialist services.

Consumers said staff support their emotional and psychological needs, and registered and care staff could describe individual strategies to support consumers.

The Assessment Team observed staffs’ frequent happy interactions with consumers who have significant functional and cognitive decline. Staff were also providing activities for those consumers and positioned consumers close to therapeutic objects they could touch and move.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies and is promoting consumers’ emotional and psychological wellbeing through individualised strategies. Therefore, it is my decision that this requirement is compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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

The Performance Report dated 12 October 2022 found the service non-compliant with requirements 5(3)(b) and 5(3)(c) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* The service environment was not clean, safe, well-maintained and comfortable, and did not enable consumers to navigate easily or move freely.
* Furniture, fittings and equipment were not clean, well-maintained or suitable for consumers.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* Rearranged and decluttered existing storage rooms, and built a new storage room.
* Created a new common/lounge space.
* Implemented spot audits for the bathrooms and general cleaning to monitor the effectiveness of the new bathroom cleaning procedure.
* The designated outdoor smoking area was moved to the back of the service, and the front courtyard has new furniture and a new pergola. No cigarette smell was present in this area.
* Re-organised the service’s dining rooms to reduce overcrowding and excessive noise in the Palamas area.
* Removed all old, worn, and torn furniture and equipment and replaced them with new furniture for all indoor and outdoor spaces.
* Weekly monitoring of all furniture, fittings and equipment by management, maintenance and housekeeping staff.

The Assessment Team observed:

* An environment that was clean.
* New furniture for both indoor and outdoor areas being used by consumers. The furniture had armrests and a high base to assist consumers transferring on and off.
* Consumers moving freely throughout the service, with no clutter or storage of equipment observed in hallways or in common areas.
* Consumers seated at multiple dining tables throughout the service at mealtimes.
* Cleaning staff attending to their tasks.
* Equipment, linen, personal protective equipment, and bins stored in designated areas and cupboards, leaving hallways and common areas easy to access and navigate.
* Hoists and lifting equipment to be clean and with wipes attached to them.

Consumers/representatives stated the service is clean and they have seen improvements in the environment.

The service has undertaken renovations and created a new storeroom and common room, and rearranged where consumers are seated during mealtimes to address clutter, overcrowding and noise concerns.

Cleaning staff have a list of daily tasks to complete. Staff said they have enough appropriate equipment, including to assist with mobility and transfers of consumers. They described how equipment is cleaned between each use. The maintenance officer checks equipment, furniture, and fittings and has a schedule of maintenance tasks. Spot cleaning audits are conducted to monitor staff practice

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies in relation to the service environment. Therefore, it is my decision that these requirements are compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Performance Report dated 12 October 2022 found the service non-compliant with requirements 6(3)(c) and 6(3)(d) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* Complaints were not consistently resolved or recorded in the service’s complaints register.
* Open disclosure was not consistently used when things go wrong.
* Complaints were not consistently reviewed or used to improve the quality of care and services.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* Implemented a feedback and complaints register to capture all feedback and complaints.
* Updated the complaints policy to include a complaints management process.
* Senior staff from various departments attend consumer meetings to receive feedback and complaints.
* Consumer surveys were increased to monthly, and staff to three-monthly to ensure all feedback and complaints are captured and managed appropriately.
* Compulsory open disclosure training for staff.
* Appointment a Quality Manager to oversee the management of complaints and feedback.

Consumers and their representatives reported that the service’s response to complaints and use of open disclosure has improved and is much better. They said complaints are acknowledged and open disclosure is undertaken by management.

Care staff said they are comfortable with handling complaints from consumers and know how to escalate complaints.

The service documents all feedback and complaints in the service’s complaints register. Complaints were actioned in a timely manner and open disclosure used where appropriate. Complaints are discussed at staff meetings and reviewed by the Board.

The Assessment Contact – Site Report identified improvements made by the service as a result of feedback and complaints, including the purchase of new furniture, the design of new gardens, and the implementation of activity logs for consumers to record their engagement in activities.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies in complaints management. Complaints are recorded, actioned and used to make improvements, and open disclosure is used where appropriate. Therefore, it is my decision that these requirements are compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The Performance Report dated 12 October 2022 found the service non-compliant with requirements 7(3)(a) and 7(3)(d) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* Insufficient number of staff to deliver care and services.
* The service had identified training needs of the workforce and the training program was not meeting the outcomes required by the Quality Standards.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and improve its performance in these requirements. Improvements included:

* Registered nurse, Clinical Nurse and care staff hours were increased.
* Some staff are ‘multiskilled’ enabling flexibility of the workforce. For example, some hospitality staff are trained as carers and some registered nurses can be utilised in the carers’ roster pool.
* Call bell response times are monitored, delays are analysed, and issues are discussed at meetings and reviewed by the Board.
* A training needs analysis was conducted and an education package was delivered to staff on a wide variety of topics, including specific areas of clinical and personal care, incident management, and risk.
* Ongoing regular training needs are identified through data analysis of trends, complaints and feedback, and by speaking directly with consumers/representatives. The Assessment Team identified various examples of training delivered to staff based on consumer feedback.
* An orientation program, including ‘buddy shifts’, is mandatory for all staff.
* A new training platform is being implemented to deliver staff training which will also provide oversight and monitoring of staff training.

I am satisfied these improvements have remediated the deficiencies related to the number of staff and staff training.

The service has processes to ensure the workforce is planned and there is enough staff. Staff on unplanned leave are replaced.

Consumers and their representatives said staff are available when needed and attend quickly in response to call bells. They did not feel that staff rush when providing care and said that staff are kind and deliver good care.

Staff advised they have enough time to provide care and services in accordance with consumers’ needs and preferences, complete their assigned tasks and have allocated breaks. They said staff on leave are replaced. The Assessment Team observed staff responding to call bells promptly.

The service has a training program that includes orientation, mandatory training, role-specific training and training on the Aged Care Quality Standards. Staff have completed mandatory training. Staff said they have sufficient training to undertake their roles and demonstrated an understanding of specific topics.

Consumers/representatives were confident in the ability of staff to deliver care and services. They said staff know what they are doing and are well trained. Positive consumer feedback about care, training and increased staff numbers was recorded in May 2023 consumer meeting minutes.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that deficiencies have been remediated. The service has enough staff to deliver safe and quality care and services and that staff receive mandatory and other training relevant to their role. Therefore, it is my decision that these requirements are compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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 12 October 2022 found the service non-compliant with requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit undertaken from 16 to 19 August 2022. The deficiencies related to:

* The governing body was not accountable for ensuring the organisation’s systems, policies or practices were delivering safe and quality care and services.
* Governance systems for information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.
* Management of high impact or high prevalence risks associated with the care of consumers, and management and prevention of incidents.
* Clinical governance systems.

The Assessment Contact – Site Report identified evidence that the service has taken actions to remediate the deficiencies and is meeting the above requirements. Improvements included:

* Created a role of Quality Manager that conduct audits against the Quality Standards.
* Implemented an audit program against the Quality Standards and process to document quality issues and actions, and add them to the service’s plan for continuous improvement.
* Established risk registers to manage risks to consumers and risks to the organisation (including non-compliance with the Quality Standards and clinical risks).
* Implemented a process to capture and analyse quality data and clinical data and issues, and to report issues to the Board. There are processes that enable the Board to respond to quality information from the service.
* Improved organisational wide governance systems:
  + An electronic care management system was implemented to manage care assessments, care planning, clinical monitoring, incidents and other information. The system’s information collection processes have improved the management of continuous improvement activities and regulatory requirements such as the management of restrictive practices and serious incident reporting.
  + The service has an up-to-date plan for continuous improvement, which includes issues and actions related to incidents, complaints, quality audits and clinical records.
  + Changes to the roster and increase staff numbers have been effective.
  + The service has effective processes to monitor aged care legislation and regulations, and the service is meeting requirements for restrictive practices and the serious incident response scheme.
  + New processes are in place to record and action all feedback and complaints in a register and this is linked to the service’s continuous improvement system.
* New registers have been developed for risk. An organisational risk register identifies key risks and mitigation strategies, including those risks associated with non-compliance with the Quality Standards.
* New registers document all restrictive practices.
* Management and staff have completed training in restrictive practices and other relevant topics.

Consumers and their representatives were satisfied with the quality of care and services and service management and said they are supported to take risks.

Staff were satisfied with improvements in staffing, training and information management.

The quality management system is effective and allows the Board to oversee the delivery of safe and quality care and services and take actions when required. Regular meetings at the service level and the Board level allow ongoing monitoring of the effectiveness of the service’s governance systems. Board members and management complete relevant training, including in risk and governance

Key quality data, such as incidents, weight loss or gain, skin tears, infections, call bell response times, SIRS reports, staff training, complaints and information from audits is collected and analysed and a summary of this data is regularly reported to the Board.

The organisation has effective organisational wide governance, risk management and clinical governance systems.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies in relation to organisational governance. Therefore, it is my decision that these requirements are 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)