Performance

Report

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| Name of service: | St Patrick's Green |
| Service address: | 40 Chapel St Kogarah NSW 2217 |
| Commission ID: | 1063 |
| Approved provider: | Greengate Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 March 2023 |
| Performance report date: | 8 April 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 Patrick's Green (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment conducted 2 March 2023, 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 22 March 2023
* the following information given to the Commission, or to the assessment team for the Assessment Contact - Site of the service: Providers Plan for Continuous Improvement dated 13 July 2022, Directions Notice dated 29 June 2022 following Site Audit 26-29 April 2022, Performance Report dated 14 June 2022 following Site Audit conducted 26-29 April 2022, Site Audit Report, for the Site Audit conducted 26-29 April 2022.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

**Areas for improvement**

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Requirement 3(3)(a)** The approved provider must demonstrate that pain management, wound management and falls management is effective and that chemical restraint and restrictive practices is practically understood by all staff. That call bells are responded to immediately and that call bells and drinks are easily accessible for consumers.

**Requirement 7(3)(a)** The approved provider must demonstrate that there are sufficient staff to respond to consumers in a timely manner and that any request for review of condition or pain management should be escalated to the Registered Nurse and responded to immediately.

**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**

This Requirement was found non-compliant following a Site Audit from 26 to 29 April 2022. During the Site Audit the Assessment Team identified consumers treatment by staff at times was not always dignified or respectful with their identity, culture and diversity valued. The service has provided training for staff on cultural diversity and respectful engagement with consumers. A review of all consumers from a culturally and linguistically diverse (CALD) background has been conducted and care plans updated. However, during the Assessment Contact visit interviews with consumers/representatives identified that some staff practices result in consumers not always being treated with dignity and respect at all times.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement, Dignity of Risk and care plans detailing the needs for the consumer which demonstrate that the consumer’s wishes are respected with their culture and diversity valued.

I have considered the information provided to me in relation to manual handling of consumers and feel that this is better suited to Requirement 3(3)(a).

I have reviewed the information provided to me by the approved provider including the previous Plan for Continuous Improvement and the current Plan and I find that the provider has addressed the previous non-compliance in this requirement and is compliant with Requirement 1(3)(a).

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |

**Findings**

This Requirement was found non-compliant following a Site Audit from 26 to 29 April 2022. Each consumer was not receiving effective personal care, clinical care that is best practice, tailored to their needs and optimises their health and well-being. The service has implemented actions to improve the delivery of care provided at the service. However, the Assessment Team identified non-compliance with this Requirement during the Assessment Contact.

The Assessment Team interviewed consumers and representatives and while some consumers and representatives interviewed provided positive feedback about care delivery, some had concerns in relation to individualised care, pain management and appropriate review of psychotropic medications.

The Assessment Team reviewed the service’s documentation which showed the majority of consumers are receiving psychotropic medication. Documentation reviewed revealed all consumers prescribed a chemical restraint had not been identified as being chemically restrained nor had appropriate consent forms in place The authorised consent for the chemical restraint and psychotropic medication according to the service policy is required to be updated every three months along with their medication. However, some authorisations were outdated and have not been updated since 2021.

A review of care and service documentation for consumers with pressure injuries and wounds showed wounds were not regularly checked or measured as per the consumer's care plan. Photographs of wounds were not accurately taken to demonstrate best practices in accordance with the service’s wound policy. Pressure injuries were incorrectly classified, or no classification was noted. Skin assessments and skin integrity care plans were not being reviewed and updated. Deterioration of wounds was not recognised, and referrals to appropriate health professionals were not attended.

The Assessment Team identified that pain management is not demonstrated as best practice or tailored to meet consumers' needs and well-being. Some consumers and representatives expressed concern about pain management. Pain for many consumers is not recognised and responded to appropriately. Pain assessments are not attended to when pain is recognised, monitored, or interventions reviewed. The Assessment Team observed a consumer crying out in pain without any response from staff, the consumer advised they had been experiencing this pain over the past few weeks, however the consumers pain chart did not reflect this as no pain was identified in pain charts during this period. The consumer’s call bell was out of reach and the Assessment Team used this to call staff, after 5 minutes no staff responded so the Assessment Team went to find someone, who eventually came to assist. This consumer’s pain was not escalated to a Registered Nurse.

The Assessment Team spoke with a representative who complained that when staff move the consumer, they are rough and hurt an existing injury that the consumer has. The representative said this has happened on multiple occasions. The representative said communication around care is bad; the representative said last week, they had asked the physiotherapist to review the consumer’s injury during the week, and when the representative came back on the weekend and asked the RN looking after the consumer the RN was unaware about the situation. The Assessment Team reviewed the consumers pain assessment and care plan and although it identified the pain, there was no interventions documented in the pain management strategies.

On further review of care documentation, the Assessment Team identified deficits in relation to falls management, neurological observation and pain management. Care documentation revealed for one consumer that they had 15 falls between December 2022 to February 2023. The review of the incident report for these falls does not demonstrate a thorough root cause analysis as the contributing factors that led to the falls are not captured; without identifying the actual cause that led to the fall, strategies developed to prevent the fall have not been deemed effective.

The review of fall incident reports shows that post-fall neurological observation has not been carried out per the services fall management policy. The fall management policy updated in May 2022 requires staff to attend consumer neurological observation half hourly for 2 hours, hourly for 4 hours, two hourly for 6 hours and four hourly for 72 hours. The fall management policy suggests staff conduct a pain assessment and pain chart following each fall; the review of the clinical documentation and assessment does not demonstrate that pain was assessed and monitored consistently after each fall.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement, that identified training, mentoring, meetings and audits to review the deficits in the report. However, I have reviewed both the current plan and the previous Plan for Continuous Improvement provided 13 July 2022 following the Directions notice of 29 June 2022 and note that although some of the actions appear to have been addressed there is continuing gaps and issues in relation to wound care, pain management, clinical escalation, restrictive practices, drinks and call bells left out of consumers reach and documentation.

I find that the approved provider is non-compliant with Requirement 3(3)(a).

**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 a Site Audit from 26 to 29 April 2022. Consumers and representatives stated that the service does not provide adequate activities to support consumers' quality of life and daily living. Staff and lifestyle staff stated that due to staff shortages, staff are unable to spend quality time with consumers to support their needs, goals and preferences and consumers and representatives provided feedback that meals provided were not always of suitable quality. The service implemented a number of actions to address these Requirements.

Improvements include that all consumers have been reassessed for their lifestyle choices and cultural backgrounds. Consumers and their representatives have been interviewed as part of the process. Their care plans have been updated accordingly and new activities introduced. Lifestyle staff were provided with education and support to conduct the assessments. A new lifestyle coordinator commenced their role in September 2022. He is experienced in providing lifestyle services in aged care. He said that since he commenced his role he has been very motivated to improve lifestyle services for consumers and understand their individual needs. The lifestyle coordinator stated that over time with feedback from consumers and facilitating the activities they prefer he feels that the calendar is more organised and time management of the lifestyle program has improved.

The Assessment Team interviewed consumers and representatives who felt supported to participate in their community within and outside the organisation's service environment, have social and personal relationships and do the things of interest to them. The service supports consumers to maintain social and personal connections that are important to them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer. The lifestyle staff have generated a list of consumers who do not attend group activities and are inclined to self-isolate. The lifestyle staff conduct one on one visits to these consumers and conduct activities of interest to them, for example, playing dominos, hand massages, reading magazines and conversations about family photos and other interests.

Consumers sampled said that the service provides a range of meals which are varied and of suitable quality and quantity. The service has processes in place to include consumers in the development of the menu and to provide feedback on the quality of the food provided. The catering staff explained how they review feedback from consumers and amend the menu accordingly. Meals are cooked fresh on site and served from bain-maries on each floor. Seasonal fresh fruit is always available. The menu is planned in consideration of consumer feedback, dietary needs and preferences. Consumers are offered an alternative hot meal option or sandwiches, soups and salads. Catering and care staff described specific dietary needs and preferences of consumers and how these are accommodated into the menu or individualised meals. There are established processes in place to ensure that meals and drinks are served according to consumers' dietary needs and preferences, including texture modified meals and thickened fluids. The kitchen and serveries were observed to be clean, and the service demonstrated evidence of recent food safety audits.

Requirements 4(3)(c) and 4(3)(f) have been found to be compliant.

**Standard 7**

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |

**Findings**

Requirement 7(3)(a) was found non-compliant following a Site Audit from 26 to 29 April 2022. The service was unable to demonstrate that the workforce is planned to enable, and the number and mix of members of the workforce deployed enable, the delivery and management of safe and quality care and services. The service has implemented actions to improve the management of the workforce. However, during the Assessment Contact, the Assessment Team identified non-compliance with this requirement.

The Assessment Team found that while management provided examples of how they ensure there are sufficient staff at the service and provided a record of a low percentage of unfilled shift hours. Most sampled consumers and representatives considered the service did not have enough staff, and some consumers were able to provide examples of the adverse impacts staffing had on their health and well-being. Consumer’s provided feedback that they do not receive timely clinical and personal care, are not supported for daily living or exercising, and worry about staff being overworked. One consumer said that they get the services they need when they need them, staff do not have time to sit and talk with consumers. The consumer said sometimes staff come in to turn off their call bell and tell the consumer they will come back later.

Feedback from representatives included that there are not enough staff at the service. One representative said that the consumer often needs to wait for staff to assist with toileting, changing, support with meals and adjusting the bed. The representative stated, 'last week, I asked a staff member to change the consumer at 12:00 pm, and they did not come until 2:30 pm; two and half hours later, when I asked them, they said one staff member was on a break, and we need two people to assist'. The representative said it happens on days when the representative is onsite; and is more concerned about what happens when they are not there.

The Assessment Team spoke with staff who corroborated consumer comments, and staff felt they did not have enough staff on the floor meant they were unable to provide consumers with the one-on-one engagement they needed. For example, one staff member said there are two staff and one care partner in the afternoon. When one staff goes on their break, there is only one care staff on the floor, resulting in compromised care for the consumer. Another care staff said care partners are allocated to dispense medication and help out on the floor. Staff said finishing that and assisting on the floor usually takes a lot of time. Six staff members said they never get time to spend with a consumer to provide one-to-one care as they are always rushed.

When this was raised with management, they stated that no shifts had been unfilled. The general manager acknowledged that there are staffing issues and said it has been difficult with the work culture and staff turnover.

The Assessment Team requested the monitoring of the call bell system. However, the general manager said there had been an issue with generating the call bell report for the last three months. Hence, the call bell report for the last three months was only sent to the general manager on the morning of the Assessment Contact. When asked how the service monitored if the calls were being answered on time, the management team said by walking around at different times and encouraging staff to answer them. The service provided information on what they classify as an appropriate response for call bells. They stated that any call bells above 10 minutes would trigger an investigation and follow-up.

During the day, the management team provided a call bell summary record they found for 24 February 2023; the review of the call bell summary for this particular day shows that there were 17 call bells above 10 minutes without answer, with the most extended call being for 1 hour. While the management team advised how they encouraged staff in the past through emails and memos to answer calls on time, they could not provide any investigation report. It was unclear how the remaining call bells would be investigated, given that the service stopped getting information generated from November 2022 to March 2023.

The approved provider responded to the Assessment Team’s report providing a copy of the Plan for Continuous Improvement with actions including reviewing and publishing a meal break schedule and review of workspaces to increase visibility of staff and ordering additional laptops for mobile portable workstations. The service also committed to address the call bell situation with training and monitoring and running reports to investigate the excess time for response. I acknowledge the actions that the provider has committed to however I have reviewed the previous plan for Continuous Improvement provided 13 July 2022 following the Directions Notice of 29 June 2022 and note that this plan had the same issues with actions including review of staffing levels and distribution of staff across levels on all shifts and review of call bell response times and to ensure there is a process of monitoring.

I therefore find that the approved provider has not addressed the previous non-compliance and find that the provider is non-compliant with this requirement.

I find that the approved provider is non-compliant with Requirement 7(3)(a).

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