Performance

Report

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| Name of service: | The Whiddon Group - Largs |
| Service address: | 64 Dunmore Road LARGS NSW 2320 |
| Commission ID: | 0335 |
| Approved provider: | The Frank Whiddon Masonic Homes of New South Wales |
| Activity type: | Assessment Contact - Site |
| Activity date: | 14 June 2023 to 15 June 2023 |
| Performance report date: | 27 July 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 The Whiddon Group - Largs (**the service**) has been prepared by G Cherry, 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 7 July 2023 including Plan for Continuous Performance (PCI)
* Performance report dated 21 February 2023

# 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 6** Feedback and complaints | Non-compliant |
| **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

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) – implement an effective system to ensure care provision is safe, effective, best practice and optimises consumers’ health and well-being; particularly in relation to pain, wound, continence, medication management, falls, clinical incident management and restrictive practices
* Requirement 6(3)(d) - implement an effective system to ensure feedback and complaints are reviewed/used to improve quality of care and services.

# 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)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Quality Standard was not fully assessed. Three of six requirements were assessed and found compliant.

A decision was made on 21 February 2023 that the service was non-compliant in requirements 1(3)(a), 1(3)(c) and 1(3)(f) after a site assessment conducted 10-12 January 2023.

Requirement 1(3)(a)

Previously the service did not demonstrate an effective system to ensure each consumer is treated with dignity and respect, with specific reference to continence care and consumers not feeling valued/accepted, placing some consumers’ sense of dignity at risk. Actions taken to address previous issues include:

* Provision of staff education relating to dignity and respect
* This topic added as an agenda item to monthly ‘resident and representative meetings’, enabling consumers/representatives an opportunity to provide feedback and/or believe further improvement is required
* Monthly staff meeting forums include discussions relating to treating consumers with dignity and respect
* A re-launch of the organisational model of care relating to relationship-based care during March 2023

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review. Sampled consumers/representatives consider consumers are treated with respect/dignity, and their identity, culture and diversity valued.

Documentation reflects consumer’s diversity, including information relating to their background, place of birth, culture, diversity, religious affiliation, family members and previous occupations. Feedback from sampled consumers/representatives include satisfaction with management and staff communication, stating they are kind, caring, respectful, easy to talk to, ensure care needs are met, and they feel safe. Documentation detailing organisational values, consumer’s rights, including the Charter of Aged Care Rights, were displayed throughout the service, and provided to consumers in the service’s welcome pack. The assessment team observed staff respectfully communicating consumer’s needs, and observed interactions to be respectful, demonstrating a caring manner.

In consideration of compliance, I am swayed by the evidence bought forward by the assessment team, consumer satisfaction and the service’s demonstration of effective systems. I find requirement 1(3)(a) is compliant.

Requirement 1(3)(c)

Previously the service did not demonstrate an effective system to ensure each consumer is supported to exercise choice and independence, including decisions relating to who and how others are involved in decisions about their care and services. Actions taken to address previous issues include:

* Documentation has been reviewed/updated relating to all consumers’ personal preferences and reflective of their current needs/preferences
* A consumer satisfaction/pulse survey was conducted to gain feedback
* Discussions at staff meeting forums in relation to consumers’ right to choose personal preferences and/or decline planned care

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review. Sampled consumers/representatives consider consumers are supported to exercise choice and maintain independence/relationships that are important to them. Interviewed staff gave examples of how consumers are supported to make informed decisions about care and services and demonstrate knowledge of organisational expectations detailed within policy documentation.

In consideration of compliance, I am swayed by the evidence bought forward by the assessment team, consumer satisfaction and the service’s demonstration of effective systems. I find requirement 1(3)(c) is compliant.

Requirement 1(3)(f)

Previously the service did not demonstrate an effective system to ensure each consumer is supported to exercise choice and independence, including decisions relating to who/how others are involved in decisions about their care and services. Actions taken to address previous issues include:

* Provision of staff education regarding maintaining consumers’ privacy/confidentiality. Further education is planned.
* Alert/reminder Signs above computers were displayed reminding staff to secure consumers’ private information.
* The topic regarding maintaining consumers’ privacy/confidentiality added to meeting forum agendas
* Ad-hoc monitoring processes conducted by management team to ensure appropriate security of consumer’s information in line with organisational expectations

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review.

Sampled consumers consistently express satisfaction their privacy is respected, giving examples of staff enquiring who consumers would like to be contacted in relation to their care. The assessment team observed staff communicating with (and about) consumers in a private/confidential manner. Systems ensure confidentiality of consumers personal information. Organisational procedure and policy documentation provides staff guidance relating to consumers’ privacy

In consideration of compliance, I am swayed by the evidence bought forward by the assessment team, consumer satisfaction and the service’s demonstration of effective systems. I find requirement 1(3)(f) is 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. | Non-compliant |

Findings

The Quality Standard was not fully assessed. One of seven requirements was assessed and found non-compliant.

A decision was made on 21 February 2023 that the service was non-compliant in requirement 3(3)(a) after a site assessment conducted 10-12 January 2023. The service did not demonstrate an effective system to ensure safe care delivery in relation to environmental restrictive practices; and staff did not demonstrate an understanding of what constitutes environmental restraint. Actions taken to address previous issues include:

* Allocated of online learning modules for staff completion relating to restrictive practices
* Management to complete monthly auditing/monitoring/review of restrictive practice and review of consumers experiencing a decline in functionality, which may lead to changes in mobility and/or environmental needs

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review.

The service did not demonstrate a system to ensure care provision is safe, effective, best practice and optimises consumers’ health and well-being. The assessment team bought forward inconsistent care provision relating to pain, wound, continence, medication management, falls, clinical incident management and restrictive practices resulting in negative consumer outcomes.

One consumer expressed dissatisfaction in relation to pain management noting staff did not assess pain requirements prior to wound care intervention. Documentation review detailed pain management review and/or assessments not occurring as a result of severe pain, nor offered/administered prior to wound care management. Directives from a wound care specialist upon review of wound were not consistently documented as occurring and interventions not consistently documented in one area to guide care delivery. The service did not demonstrate an effective/consistent system in relation to wound photography. Review of consumer’s documentation detail care delivery not as per best practice, nor demonstrate accurate review of wound progression/healing. Wound photography occurred from differing angles and note inconsistent measurements. Identified allergies were not adhered to resulting in possible wound deterioration.

For one consumer who sustained a fracture following a fall, documentation did not demonstrate staff conducted a pain assessment, prior to medical officer referral requesting analgesia and/or conduct post fall assessments (including neurological observations) prior to hospital transfer. Appropriate, effective continence management interventions were not demonstrated in a timely manner in relation to a consumer identified as experiencing constipation following administration of opioid medication. For another consumer who experienced a fall (and reported experiencing pain during care activities) pain assessment was not evident, nor report of an incident. The assessment team note discrepancies between consumer’s documentation and reported incidents. Via review of 3 consumers documentation, they note several incidents not reported, as a result the service’s clinical incident management processes are not effectively identifying and/or actioning incidents to identify cause and/or implement strategies to minimise risk of occurrence. Interviewed management advise an inability to monitor and/or search consumers’ progress notes to identify any unreported incidents due to issues with their electronic care management system. While the deficit has been reported to the information technology team, resolution has not occurred.

In their response, the approved provider acknowledge room for improvement in achieving safe and clinical consumer care and developed a detailed action plan to address gaps. They advise recent/and planned appointment of senior management personnel, additional staff (including nurse practitioner), plus newly implemented processes, oversight by clinical manager and alignment with organisational governance programs will result in improved outcomes. In relation to sampled consumers, retrospective documentation, and review of incidents occurred. Actions include review of restrictive practices to ensure accurate/current details, staff education/training, monitoring processes, electronic handover processes, policy and guidelines updated.

In consideration of compliance, I acknowledge actions taken and accept the approved provider’s PCI details responsibility and anticipated completion timeframes; however, am swayed by the volume of evidence resulting in negative consumer outcome. I consider it will take some time for the approved provider to demonstrate sustainability of newly engaged management team, newly implemented processes, plus effectiveness of education/training to improve quality of care/service and demonstrate compliance. The service does not demonstrate an effective system to ensure care provision is safe, effective, best practice and optimises consumers’ health and well-being; in particular relating to pain, wound, continence, medication management, falls, clinical incident management and restrictive practices resulting in negative consumer outcomes.

I find requirement 3(3)(a) is non-compliant.

# Standard 6

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

Findings

The Quality Standard was not fully assessed. One of four requirements was assessed and found non-compliant.

A decision was made on 21 February 2023 that the service was non-compliant in requirement 6(3)(d) after a site assessment conducted 10-12 January 2023. The service did not demonstrate feedback utilised to inform change and improve quality of care and services. Actions taken to address previous issues include:

* Provision of staff education relating to organisational expectation to embrace feedback/complaints as an opportunity to improve consumers’ care/service delivery
* This topic added as an agenda item to all meeting forums
* Met with consumers to ensure they feel valued and safe in raising concerns
* Distribution of organisational ‘Have your say’ form to all consumers and representatives
* Review meeting minutes from previous 6 months to ensure concerns raised by consumers/representatives are identified, addressed/resolved and concerns raised during meetings recorded/reviewed to identify trends

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review.

The assessment team bought forward evidence the service was not able to demonstrate they manage complaints effectively to achieve successful outcomes. They did not demonstrate complaints are resolved to consumer/representative satisfaction. Some sampled consumers/representatives note dissatisfaction in lack of response, resolution when feedback/complaints are communicated to management. Monitoring/review of actions taken in response to feedback to ensure effectiveness and/or complainant satisfaction is not evident; nor active management/resolution/review/recording to inform continuous improvement actions.

In their response, the approved provider acknowledge slow progress had been self-identified in relation to previous non-compliance resulting in additional actions, including recent/and planned appointment of senior management personnel and additional staff. In particular to this requirement while acknowledging room for improvement, they note historical timeframes of examples advising organisational personnel contacted each named consumer/representative to ascertain resolution/satisfaction. While citing examples of recent improvements did not evidence these resulted from feedback received. They commit to creating an environment where complaints are viewed as valuable opportunities to improve service delivery.

In consideration of compliance, I acknowledge actions taken and accept the approved provider’s PCI details responsibility and anticipated completion timeframes; however, I consider it will take some time for the approved provider to demonstrate sustainability of newly implemented processes, plus effectiveness of education/training result in outcomes demonstrating feedback/complaints are reviewed and used to improve/inform quality of care and service. I find requirement 6(3)(d) is non-compliant.

# Standard 7

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| Human resources | |  |
| 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

The Quality Standard was not fully assessed. Two of five requirements were assessed and found compliant.

A decision was made on 21 February 2023 that the service was non-compliant in requirements 7(3)(d) and 7(3)(e) after a site assessment conducted 10-12 January 2023.

Requirement 7(3)(d)

Previously the service did not demonstrate an effective system to ensure staff receive training to support them in their role and deliver outcomes required by the Quality Standards. Actions taken to address previous issues include:

* Communicated with staff the importance of completing education, specifically mandatory training. Online mandatory training modules to be reset for all staff completion
* The service’s management team to conduct a needs analysis to determine gaps in staff knowledge
* Development a culture of learning by embracing subjects of staff interest, implementing these with mandatory training topics such as Serious Incident Response Scheme (SIRS), Aged Care Quality Standards, and restrictive practices

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review.

While most sampled consumers consider staff have required skills to meet their needs and effectively carry out duties of their role, some representatives express a need for staff training, citing examples of skills deficit relating to manual handling and medication management. Feedback includes staff rushing when providing care, plus lack of regularly attending consumer’s personal hygiene needs.

Interviewed staff demonstrate knowledge of consumers care. However, the assessment team note not all staff members receive an orientation process and/or individual support upon commencement. While organisational expectations state all staff administering medications require demonstration of competency, the service did not demonstrate an effective system of ensuring this occurs; resulting in one care staff administering medications without being deemed competent to do so. The assessment team note repeated medication errors did not result in training to ensure staff competence. Management advise planned competencies to be conducted noting an increase in staff completion of required training modules within the past 3month period. Via observation, the assessment team note inappropriate staff practices relating to infection control prevention; for example, overflowing soiled linen and personal protective equipment (PPE) containers in communal areas. The organisation’s educator advised annual staff hand hygiene/infection control competency assessments are planned.

In their response, the approved provider cites a 50% improvement/increase in staff completion of required training and refutes some evidence bought forward by the assessment team, noting medications administered as required, and a decrease in medication incidents. Immediate training of staff occurred in relation to infection control requirements, appropriate storage units obtained and ongoing monitoring to ensure compliance. While acknowledging appropriate orientation did not occur for one care staff, management ensured completion of competency assessment prior to further assisting consumers with medications, noting 100% of staff assisting consumers with medication have completed assessments demonstrating competency.

In consideration of compliance, I acknowledge immediate actions taken by the approved provider, plus planned actions to ascertain future training needs and accept evidence supplied. I find requirement 7(3)(d) is compliant.

Requirement 7(3)(e)

Previously the service did not demonstrate an effective system of regular assessment, monitoring and review of each staff member’s performance. Actions taken to address previous issues include:

* Current senior management developed a recording and monitoring process to ensure completion of overdue staff performance appraisals (current completion = 20%)
* An introductory meeting with all staff demonstrating performance appraisal process, to address and a follow-up meeting scheduled within 3 months

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review. New staff advise of not being supported in their role and no receipt of feedback in relation to their performance during their probationary period. While regular assessment, monitoring/review of each staff’s performance is not consistently occurring, a monitoring process has been developed to ensure completion as per organisational requirements/framework. Most interviewed staff state performance appraisals occurred during the past year, and demonstrate knowledge of current processes, including communication with management team, noting no further involvement in the process. While the assessment team note a lack of performance review relating to medication errors management demonstrated the performance management process conducted in relation to identified manual handling deficits for one staff member. In their response, the approved provider note relaunch of performance appraisal processes, including a monitoring/recording process and a planned completion date.

In consideration of compliance, I acknowledge actions taken/and future planned actions, plus demonstration of performance management processes to identified deficits. I find requirement 7(3)(e) is compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

The Quality Standard was not fully assessed. One of five requirements was assessed and found compliant.

A decision was made on 21 February 2023 that the service was non-compliant in requirement 8(3)(c) after a site assessment conducted 10-12 January 2023. The service did not demonstrate an effective organisation wide governance system in place relating to workforce governance, regulatory compliance and feedback and complaints. Actions taken to address previous issues include:

* Monthly clinical indicator report now includes details of new, and status of existing complaints which are communicated to organisational Quality Care and Compliance team
* The service benchmarks complaints against other services within the organisation and the aged care sector’s performance
* The organisation’s regional Quality Team to conduct auditing/monitoring processes and provide oversight

During the assessment contact conducted 14 to 15 June 2023, information was gathered through interviews, observations. and document review. The assessment team bought forward evidence the service did not demonstrate effective organisational governance relating to information management, continuous improvement, workforce governance, and regulatory compliance. Nor demonstrate how systems and/or processes are monitored to ensure they remain effective and/or to identify deficiencies.

An electronic management system records care documentation and incidents are recorded within a risk management system. The assessment team bought forward evidence not all incidents are reporting to enable analysis/review and/or implement actions to prevent reoccurrence, plus an inconsistent method of recording wound management care. Interviewed staff detail ability to access information regarding consumers’ care needs via care planning documentation and/or staff handover discussions and organisational policies/procedures to guide care delivery, noting verbal communication not consistently effective. Communication with consumers/representatives occurs via a range of methods such as email, noticeboards, and meeting forums.

A system of auditing/internal monitoring is utilised as a means of identifying improvement opportunities. In response to feedback during the assessment contact in January 2023, management initiated a range of improvement activities to address some identified deficiencies. The assessment team note not all previously identified deficits recorded within the PCI. Management detailed creation of a current action plan, to enable recording of issues/feedback/actions/planned strategies and designated timeframes for completion. Assignment of financial delegations ensure expenditure within budget organisational support in relation to out of budget items when required. The assessment team bought forward evidence in relation to workforce governance systems which is considered in requirements 7(3)(d) and (e).

Management advised information on regulatory changes is initially identified by management/senior staff and updates sourced from government bodies/industry peak organisations. Interviewed staff demonstrate awareness of communication systems/meeting forums to disseminate information. Education relating to reportable requirements is part of the service’s mandatory education program; documentation detail monitoring processes to achieve completion and interviewed staff demonstrate knowledge of reporting responsibilities. Via documentation review, the assessment team note a lack of reporting and/or investigation as to legislative requirements for one consumer. The assessment team bought forward deficits relating to currency of authorisation and decision-making responsibilities regarding use of medication deemed as a restrictive practice. Authorisation processes are not being regularly reviewed to ensure currency (considered in requirement 3(3)(a).

There is a process of information transfer regarding feedback/complaints from management to the regional manager and various governance teams/board members. Consumer/representative feedback relating to feedback/complaints management is considered within requirement 6(3)(d).

In consideration of compliance, organisational systems are evident, noting deficits relating to incident reporting and clinical care provision at the service level. Consumer impact is considered within requirement 3(3)(a). In addition, I acknowledge actions taken/and future planned actions, plus demonstration of performance management processes to identify deficits.

I find requirement 8(3)(c) is 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)