Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | The Whiddon Group - Wingham - Primrose |
| Commission ID: | 0186 |
| Address: | 12 Primrose Street, WINGHAM, New South Wales, 2429 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 14 August 2024 |
| Performance report date: | 19 September 2024 |
| Service included in this assessment: | Provider: 769 The Frank Whiddon Masonic Homes of New South Wales  Service: 202 The Whiddon Group - Wingham - Primrose |

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 - Wingham - Primrose (**the service**) has been prepared by Therese Solomon, 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 (performance assessment) – 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 6 September 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not Compliant |
| **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)

* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, tailored to their needs and optimises their health and well-being.
* Ensure behaviour support plans are current and detailed for all consumers.
* Ensure wounds are consistently managed according to directives, and wound documentation is according to best practice guidelines.
* Ensure effective pain management and documentation for all consumers.

# 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. | Not Compliant |

Findings

Requirement 3(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including conducting an audit on the polypharmacy and antipsychotic use at the service.

During the Assessment Contact conducted on 14 August 2024, the service provided evidence that the actions listed in their quality improvement log had commenced and they were working to ensure sustainability of these actions. Observations and a review of care and service documentation showed that deficits previously identified are being addressed through changes outlined in the quality improvement log.

However, it was identified that not all deficits have been resolved, as the service could not demonstrate all changes implemented are effective and sustainable. There were also new deficits identified related to wound management.

A review of care and service documentation for consumers with known changed behaviours showed these behaviours had not been managed appropriately. Behaviour support plans were not personalised, nor did they include information about behaviour triggers, or individualised interventions and activities which meet the needs of each consumer.

The service demonstrated restrictive practice management is according to best practice and legislative requirements, relating to regular review, informed consent, and the development of behaviour support plans when restrictive practices are implemented. The use of restrictive practices is tailored to consumer needs to optimise their health and wellbeing. Assessment and care planning reflects the consideration of restrictive practices. However, not all behavioural supports are individualised based on each consumer’s needs.

The service has processes in place to ensure the use of restrictive practices are assessed, planned, and reviewed to minimise usage. The registered nurses described the service policy for restrictive practice, including that it is only used as a last resort, how informed consent must be obtained, and that reviews are conducted every 3 months or when there are changes to the consumer’s care needs and preferences. The service has also been working on reducing the number of consumers subject to restrictive practice. During June 2024 and July 2024, the service has ceased 2 mechanical restraints, 2 chemical restraints and one environmental restraint.

Review of clinical documentation highlighted that consumers with chronic wounds and/or pressure injuries were referred to a wound specialist. However, deficiencies related to effective wound monitoring were observed and wounds were not consistently managed according to wound care directives. In addition, pressure injuries were not always identified at an early stage.

Wound charting and documentation were identified as an area for improvement. Initial assessments did not consistently contain all required information, such as wound measurements, appearance and presence of any odour. Wound care plans include treatment goals, including the dressing products to be used and the frequency of wound care required. Wound charting reflects the wound care frequency occurs as prescribed.

Wound photographs did not consistently follow best practice processes, lacking the use of measuring devices, lacking identifying information and did not state where the pressure injury was located.

The service demonstrated pain management is not consistently considered for each consumer and is not consistent with best practice recommendations. Review of pain monitoring charts identified that pain is not always documented or reviewed. Management acknowledged there is areas for improvement needed for the monitoring, review and documentation of pain management and advised they will put actions into place to improve pain management.

Consumers experiencing pain are generally managed effectively. Alternatives to medication such as heat packs, massage, exercises, and repositioning are tried and documented in the consumer’s care and service documents. Consent for opioid pain relief is documented accordingly and reflects that risk of pain medication usage has been explained to consumers and their representatives. After the administration of opioid analgesia, including as needed medication, a review for effectiveness is completed by staff.

The Approved Provider responded with additional documentation and clarifying information. The service has already implemented actions to address areas of concern, including completing a review of all behaviour support plans to ensure they are individualised, up to date and reflective of consumers’ needs and goals, provided education and training to clinical staff on wound care and engaged with a wound consultant to provide education and support to the service.

In coming to my decision, I have reviewed the information provided by the Assessment Team and the Approved Provider. While I acknowledge the actions taken by the Approved Provider to address the identified non-compliance, the implemented actions will take time to become imbedded into daily practice and will need to be evaluated for effectiveness and sustainability.

Based on the information provided by the Assessment team and the Approved Provider, requirement 3(3)(a) is found non-compliant.

# Standard 8

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

Requirement 8(3)(c) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including completing a review of consumer care plans and behaviour support plans and ensure they are in line with the legislative and regulatory requirements.

During the Assessment Contact conducted on 14 August 2024, the service demonstrated effective organisational systems are in place for information management, continuous improvement, financial governance, workforce governance, regulatory compliance and the management of feedback and complaints.

The service has information systems in place to ensure all stakeholders have the information they need. Consumers and/or representatives are provided an information pack containing information about what to expect when they first move into the service and the ongoing care and services that will be provided.

Management and staff stated consumers and representatives receive information through various means such as residential meetings, consumers advisory meetings, newsletters, email correspondence, board reports, monthly resident service manager reports and members of the executive team visiting consumers at each site to communicate directly with consumers and staff at the service. All meeting minutes are distributed to those unable to attend. Feedback mechanisms are in place for all stakeholders and policies and procedures are available to all staff on-line.

The service has a continuous improvement system in place and identifies opportunities for improvement through consumer feedback, complaints, audits, surveys, resident meetings, feedback and suggestions from consumer advisory meetings and food focus groups, staff suggestions, observations, review of clinical indicators, incidents, organisational initiatives, and external reviews. The continuous improvement process is monitored at a service and organisational level and is supported by the quality and compliance team. Continuous improvements are submitted to the board for their review and endorsement. A review of the plan for continuous improvement showed improvements are logged, implemented, and evaluated.

Management advised preparation of the yearly forecast and budget are carried out by the executive team based in the organisation’s head office. To understand what the service may need, a review of consumer care needs and the workforce requirements is conducted. Management provided examples of where they have utilised their recent budget funding to fund a hair salon on the ground floor for consumers. The Assessment Team observed construction works were being carried out on ground floor during the visit.

The management team stated they have the resources they need for effective and safe care delivery. A budget and a delegation authority for discretionary spending is given to the management team, and they can approach the executive and seek authorisation for further spending if required.

The workforce is monitored at both the service and organisation level. The service demonstrated planning of its workforce is managed through ongoing review of consumer care needs, clinical data, feedback from consumers and staff. The service has a stable workforce. Duties and responsibilities for all roles are clearly set out in position descriptions and management regularly monitor and review the performance of staff. The service is supported by an organisational human resource team, learning and development management team. These teams have oversight over training and education and recruitment processes.

The organisation demonstrated they have effective processes in place to ensure that roles and responsibilities are clearly defined for management and staff in relation to allocation, monitoring, reporting and completion of mandatory training.

Management advised industry standards and guidelines, regulatory and legislation updates and information are monitored by the organisation’s executive team through subscriptions to various legislative services and peak bodies and regular updates from government bodies. The organisation’s policies and procedures are updated to reflect the changes. The organisation provides the service’s management teams and staff with regular updates on legislative and policy changes and any new or updated organisational policies and procedures. Management keep staff updated regarding any changes to legislation or regulatory information through staff meetings, toolbox sessions, resources on staff notice boards and electronic messages to staff.

The service demonstrated feedback and complaints are used to inform continuous improvement. Complaint trends are monitored at the service and organisation level with relevant information provided to the governing body. A summary of all complaints is reported at all meetings. The service demonstrated systems are in place to encourage and provide opportunity for consumers and/or representatives and staff to provide feedback and complaints. Feedback and complaints are fed to the board quarterly for review as part of their board meetings.

It is noted the service has made significant changes and improvements into their organisation wide governance systems relating to information management, continuous improvement, workforce governance and regulatory compliance.

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)