Performance

Report

**1800 951 822**

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| Name of service: | The Whiddon Group - Wingham - Primrose |
| Service address: | 12 Primrose Street WINGHAM NSW 2429 |
| Commission ID: | 0186 |
| Approved provider: | The Frank Whiddon Masonic Homes of New South Wales |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 July 2023 to 20 July 2023 |
| Performance report date: | 6 September 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 - Wingham - Primrose (**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 21 August 2023 including action plan dated 11 August 2023
* Performance Report dated 17 June 2022

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | Non-compliant |
| **Standard 5** Organisation’s service environment | Non-compliant |
| **Standard 6** Feedback and complaints | Non-compliant |
| **Standard 7** Human resources | Non-compliant |
| **Standard 8** Organisational governance | 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 1(3)(d) - implement an effective system to ensure consumers are supported in understanding possible outcomes of risk-taking activities and mitigation strategies are identified/implemented and known to consumers and staff.
* Requirement 2(3)(a) – implement an effective system to ensure reassessment and documentation of current needs (to guide care delivery) consistently occurs when consumers return from hospital, plus consumer’s choice is considered in relation to hygiene cares.
* Requirement 3(3)(a) – implement effective systems to ensure consumer receives safe, effective personal/clinical care specifically upon return from hospital, appropriate management of restrictive practices, wound management and hygiene needs.
* Requirement 5(3)(b) – implement an effective system to ensure consumers are supported to freely move throughout a safe, clean, well-maintained, comfortable environment.
* Requirement 6(3)(d) – ensure a system effectively captures/utilises feedback and complaints to inform/improve quality care and services.
* Requirement 7(3)(d) – implement an effective process to ensure provision of staff education/training regarding topic related to Quality Standards, in particular restrictive practices, and legislative requirements.
* Requirement 7(3)(e) – ensure an effective system to monitor/review staff performance.
* Requirement 8(3)(c) – implement systems to ensure organisational wide governance systems are effective at a service level in all aspects of this requirement however specifically in relation to information management, workforce governance and regulatory compliance.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |

Findings

The Quality Standard was not fully assessed; one of six requirements was assessed and found non-compliant.

A decision was made on 17 June 2022 the service was non-compliant in requirement 1(3)(d) after an assessment contact visit 10-12 May 2022 as they did not demonstrate appropriate risk assessments were conducted nor dignity of risk discussions occurring for consumers who choose to take risks. Staff did not demonstrate knowledge of consumer risk or mitigation strategies in relation to risk-taking activities of choice. In response, actions include reviewing all named consumers to ensure re-assessment/updating of care planning documentation, completion of risk assessments and development/implementation of interventions to address/mitigate risks.

During this assessment contact information was gathered through interviews, observations, and document review. Some sampled consumers express satisfaction in ability to participate in activities/take risks as per their choice, such as independently leaving the service via an electric wheelchair. Not all had participated in discussions relating to risks associated with chosen activities. Interviewed staff did not demonstrate an understanding of the concept of dignity of risk to enable consumers to live their best lives nor explain how they support consumers to undertake risks.  In their response, the approved provider advised reintroduction of guidance documentation to ensure comprehensive assessment and supplied evidence of completed documentation for 2 sampled consumers relating to risk. However, they did not reveal consumer involvement to demonstrate understanding of possible outcomes/nor strategies to minimise/mitigate risk. In consideration of compliance, while I acknowledge some consumers are participating in activities of choice; the service does not demonstrate consumers are supported in understanding possible outcomes of risk-taking activities and mitigation/minimisation strategies are identified/implemented. I find requirement 1(3)(d) is non-compliant.

# Standard 2

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| 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. | Non-compliant |

Findings

The Quality Standard was not fully assessed; one of five requirements was assessed and found non-compliant.

A decision was made on 17 June 2022 the service was non-compliant in requirement 2(3)(a) after an assessment contact visit 10-12 May 2022 as they did not demonstrate consideration of risks to consumer’s health/wellbeing informs delivery of safe/effective care and services. Specifically lack of individual details within Behaviour Support Plans (BSP’s) for consumers subject to restrictive practices and incomplete risk assessments when required. In response, actions include reviewing all named consumers to ensure re-assessment/updating of care planning documentation, completion of risk assessments and development/implementation of interventions to address/mitigate risks.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrates some aspects of assessment/planning, however processes to ensure assessment of risk occurs when consumers return to the service post hospitalisation are not consistently effective. Via document review the assessment team note 2 consumers who recently returned from hospital were not reassessed in a timely manner to determine current needs. Management acknowledges lack of process/policy to guide staff on assessment completion, and interviewed clinical staff did not demonstrate awareness of assessments required. The impact of this deficit is considered in requirement 3(3)(a). In addition, the assessment team note some assessment processes regarding regularity/timeliness of personal hygiene did not consistently involve consumers/representatives to ensure consideration of individual choice.

In their response, the approved provider states an inability to maintain previously implemented improvements due to leadership/staffing challenges and current building renovation, noting implementation of further improvements to address non-compliance. These include appointment of two Nurse Consultants, postponing new consumer admissions, realignment of staff knowledge in relation to organisational policy/expectations, introduction of new processes, plus provision of staff education/training. While acknowledging responsive actions, I consider it will take some time to demonstrate effectiveness/sustainability of newly engaged clinical team, new processes, plus effectiveness of education/training to improve quality of care/service. The service does not demonstrate an effective system to ensure reassessment/documentation of current needs to guide care delivery consistently occurs, particularly when consumers return from hospital. I find requirement 2(3)(a) is non-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 |
| 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 Quality Standard was not fully assessed; two of seven requirements were assessed, and one found non-compliant.

Requirement 3(3)(a)

The service did not demonstrate effective systems to ensure each consumer receives safe, effective personal/clinical care as per principles of best practice and tailored to individual needs to optimise health and well-being. While interviewed registered nurses detail review of hospital discharge summaries inform reassessment within 24 hours of a consumer returning from hospital, the assessment team note this does not consistently occur. Via document review and interview with consumers/representatives the assessment team note appropriate reassessment did not occur in a timely manner to identify changes in condition for one consumer upon return from hospital, resulting in acute wound deterioration requiring antibiotics and subsequent further hospitalisation. In addition, lack of mobility assessment and lack of appropriate hygiene/continence care resulted in excoriation, and wound monitoring records, incident reporting did not occur. Management notes lack of policy/procedure to guide staff relating to review/reassessment post hospital discharge.

The service did not demonstrate effective management of restrictive practices. Demonstration of use of psychotropic medication as a last resort is not evident for all consumers nor management of environmental restraint appropriately addressed. Consumers are not supported to independently access different areas within the service. Interviewed staff did not consistently demonstrate a knowledge/understanding of restrictive practices and the service did not demonstrate effective clinical oversight. Review of sampled behaviour support plans (BSPs) did not detail individualised plans containing triggers/interventions/strategies to guide staff in care delivery. Management acknowledged deficits, advising processes in place to review all BSP’s. Some sampled consumers express dissatisfaction regarding hygiene care provision not as per individual choice.

In their response, the approved provider states an inability to maintain previously implemented improvements due to leadership/staffing challenges and building renovation, noting further improvements implemented to address non-compliance. These include appointment of two Nurse Consultants, postponing consumer admissions, realignment of staff knowledge in relation to organisational policy/expectations, introduction of new processes, plus provision of staff education/training. In addition, they reviewed all named consumers to ensure safety/satisfactory outcome, supplied evidence of non-pharmalogical interventions prior to administration of medication, retrospective reporting of incidents and organisational monitoring processes. In relation to restrictive practices and behaviour support, provision of education/training is to occur, plus review of consumer’s files to ensure currency of BSPs and meeting forums to include discussions relating to these aspects.

In consideration of compliance, while acknowledging responsive actions, I consider it will take some time to demonstrate effectiveness/sustainability of newly engaged clinical team, new processes, plus effectiveness of education/training to improve quality of care/service. I find requirement 3(3)(a) is non-compliant.

Requirement 3(3)(g)

A decision was made on 17 June 2022 the service was non-compliant in requirement 3(3)(g) after an assessment contact visit 10-12 May 2022 as they did not demonstrate appropriate infection control practices consistently implemented. In response, actions include staff communication regarding personal protective equipment (PPE) use and associated policies, provision of staff education regarding clinical waste removal/storage, purchase of equipment, reinforcement of processes relating to contractors accessing the site and display of signage relating to personal testing when accessing the site.

During this assessment contact information was gathered through interviews, observations, and document review. Staff demonstrate an understanding of infection control principles and an outbreak preparedness/management plan guides staff in the event of an outbreak. A surveillance system records infection details, antimicrobial stewardship is a standing agenda item for meeting forums, an infection prevention control lead (IPC lead) guides staff practice and a consumer vaccination program exists. Medical officers order pathology prior to commencement of antibiotics. Staff were observed conducting appropriate hygiene practices, PPE use and demonstrate a general understanding of infection prevention/minimisation processes. I find requirement 3(3)(g) is compliant.

# Standard 5

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| 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings, and equipment are safe, clean, well maintained, and suitable for the consumer. | Compliant |

Findings

The Quality Standard was not fully assessed; two of six requirements were assessed, and one found non-compliant.

A decision was made on 17 June 2022 the service was non-compliant in requirements 5(3)(b) and (c) after an assessment contact visit 10-12 May 2022.

Requirement 5(3)(b)

Previously the service was found non-compliant as they did not demonstrate a safe, clean, well maintained, and comfortable environment enabling consumers to move freely both indoors and out. Some emergency fire evacuation paths were obstructed, lack of cleanliness; consumers smoking in non-designated areas, areas obstructed by clutter and a locked door preventing access to outdoor areas. In response, actions include relocation of designated smoking area, equipment cleaned (including outdoor furnishings) plus inclusion in ongoing preventative maintenance programs, purchase of cleaning trolleys with lockable compartments, and redevelopment of cleaning processes to achieve improvement.

During this assessment contact information was gathered through interviews, observations, and document review. Some sampled consumers/representative’s express satisfaction with the cleanliness of the environment however, some (residing in rooms not yet renovated) express dissatisfaction relating to rooms not consistently cleaned nor well-maintained floor coverings. Effective processes to ensure a clean and well-maintained environment enabling consumers to freely move indoors and out are not evident. The assessment team note some consumers require staff assistance to gain egress through locked doors between high/low care areas.

The service continues to undergo renovations. Some aspects are complete, including floor coverings and painting in some areas, a new communal area, new furniture and management note expected renovation completion date to be late 2023. The assessment team observe some windows inconsistently cleaned, some flooring/external areas containing residue/markings, carpet in disrepair and handrails (to support consumers safety when mobilising) removed in one area. An effective process to ensure completion of preventative maintenance is not evident.

In their response, the approved provider cites removal of handrails in some areas as a safety measure (due to limited spacing), renovations in progress will rectify painting and flooring deficits. While acknowledging lack of preventative maintenance in some areas (attributing this to incomplete renovation works) they note planned improvements via implementation of an electronic monitoring/recording/alert process. They advise, due to ongoing building works, outdoor areas (including paving) have been deemed as not viable for cleaning until renovation/building completion.

In consideration of compliance, while I accept the approved provider is in progress of addressing some aspects bought forward by the assessment team and a nominated completion date is planned, I consider it will take time to demonstrate effectiveness/sustainability of new processes, to ensure compliance with this requirement. The service has responsibility to ensure a safe, clean, well-maintained, comfortable environment (not withstanding current building activity). I find requirement 5(3)(b) is non-compliant.

Requirement 5(3)(c)

Previously the service was found non-compliant as they did not demonstrate furniture, fittings and equipment are safe, clean, well maintained, and suitable for consumers. In response, as per the service’s action plan they implemented actions as noted in requirement 5(3)(b).

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers express satisfaction equipment is suitable for their needs and purchase of new furniture as part of current renovations. The assessment team observed furniture, fittings, and most equipment to be generally clean, however note some consumer’s motorised scooters/wheelchairs not consistently cleaned as per the preventative maintenance program. In their response, the approved provider advised cleaning of motorised scooters/wheelchairs added to cleaning schedules and care plans updated to reflect cleaning responsibilities. I find requirement 5(3)(c) is 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 17 June 2022 the service was non-compliant in requirement 6(3)(d) after an assessment contact visit 10-12 May 2022 as they did not demonstrate verbal feedback/complaints raised are consistently documented and used to enable accurate complaints trending/analysis and improve quality of care and services. In response, actions include provision of training to management team members and review of meetings minutes to ensure complaints are documented.

During this assessment contact information was gathered through interviews, observations, and document review. An effective system to ensure feedback and complaints are used to improve quality care/services is not evident. Management explain quality improvement documentation is maintained via an electronic system. Sampled consumers/representatives’ express dissatisfaction while they have voiced complaints/concerns, they had not received a response and the assessment team note recording documentation did not reflect consumer feedback as communicated to them. While some improvement activities have occurred, management did not demonstrate how consumer/representative feedback is utilised to inform improvement.

In their response, the approved provider acknowledges areas for improvement; advising responsive actions include reviewing meeting minutes to identify any complaints, consult with consumers/representatives where complaints have been raised to ensure action as per organisational policy/expectations; register all complaints into organisational recording formats to enable analysis/trending, provide staff education/training and implement monitoring processes to ensure management aligns with organisational expectations. In consideration of compliance, I accept responsive actions however consider it will take time to demonstrate effectiveness/sustainability of new processes, to ensure compliance with this requirement. 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The Quality Standard was not fully assessed; two of five requirements were assessed and found non-compliant.

A decision was made on 17 June 2022 the service was non-compliant in requirements 7(3)(d) and (e) after an assessment contact visit 10-12 May 2022.

Requirement 7(3)(d)

Previously the service did not demonstrate effective processes to ensure staff completion/effectiveness of training in relation to restrictive practices, Serious Incident Response Scheme (SIRS), open disclosure and the Aged Care Quality Standards. In response, actions include provision of additional staff education/training sessions in relation to these topics plus complaints management, infection control and principles of dignity of risk.

During this assessment contact information was gathered through interviews, observations, and document review. Management explained an orientation process including initial training/support for new staff and use of an online training platform for most staff education. However, management were unable to articulate what mandatory online training sessions are required or demonstrate effective processes to monitor and ensure staff attendance. Interviewed staff did not demonstrate understanding/knowledge of recent legislative requirements. In responding to previous non-compliance management scheduled education session in early 2023 however, management note (and documentation details) an ineffective process to ensure staff attendance.

In their response, the approved provider acknowledges deficits, however, note self-identification resulted in organisational plans to update previous ineffective online training platforms, streamline processes to improve compliance, re-invigorate mandatory training program (planned commencement 2024) and engagement of an external provider to support training implementation. In addition, further mandatory training sessions have been planned. In consideration of compliance, I accept responsive actions (noting self-identification by the service) however consider it will take time to demonstrate effectiveness/sustainability of new processes to ensure compliance with this requirement. I find requirement 7(3)(d) is non-compliant.

Requirement 7(3)(e)

Previously the service did not demonstrate regular assessment, monitoring and review of the workforce performance is undertaken. Staff performance appraisals are not completed nor an action plan in place to manage completion. In response, actions include forwarding staff a copy of performance appraisal tool, scheduling appointments, plus development of a monitoring documentation to record completion of same.

During this assessment contact information was gathered through interviews, observations, and document review. The service did not demonstrate effective systems to monitor/review staff performance. Organisational policy guides annual performance review including formal opportunities for review/discussion throughout each year. Management demonstrates not all staff completed performance review however note currently conducting discussions/meetings. Interviewed staff did not consistently recall receiving review in the previous 12-month period.

In their response, the approved provider acknowledges deficits noting changes/streamlining of this process for both managers and employees to ensure completion is achievable. In addition, prioritisation relating to timeliness of past review will occur. In consideration of compliance, I accept responsive actions (noting self-identification by the service) however consider it will take time to demonstrate effectiveness/sustainability of new processes, to ensure compliance with this requirement. I find requirement 7(3)(e) is non-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. | Non-compliant |

Findings

The Quality Standard was not fully assessed; one of five requirements was assessed and found non-compliant.

A decision was made on 17 June 2022 the service was non-compliant in requirement 8(3)(c) after an assessment contact visit 10-12 May 2022 as the service did not demonstrate effective organisational wide governance systems related to continuous improvement, workforce governance, regulatory compliance, feedback, and complaints. In response, actions include topics relating to SIRS and dignity of risk added to staff mandatory training requirements.

During this assessment contact information was gathered through interviews, observations, and document review. Effective organisational systems were evident in relation to some aspects of this requirement including continuous improvement, financial governance and an overarching system relating to feedback and complaints. Audit findings are monitored and included in an organisational plan for continuous improvement when improvement activity is required; relevant subcommittees have responsibility to review/action service level data. Financial delegations ensure expenditures within budget and processes ensure out of budget purchases when required. Policies guide organisational expectations regarding feedback/complaints management. Executive personal monitor/access data to feedback/complaints to improve quality of care/services, however the assessment team note organisational expectations not evident at service level (considered in requirement 6(3)(d).

Effective organisational governance systems were not effectively demonstrated relating to information management, workforce governance and regulatory compliance at service level. Information systems include electronic care planning, quality, incident, feedback, and managements system with reporting capabilities monitored/evaluated by both organisational staff and at service level. Multiple methods are utilised to transfer data to organisational executive teams, including escalation at board level when required. However, an organisational led system to enable staff access to online training is not consistently effective resulting in staff inability to access/complete training requirements.

A workforce framework guides/directs staffing numbers to endeavour to ensure sufficient skilled and qualified staff to provide safe, respectful quality care/services.  Roles and responsibility requirements are assigned via an organisational human resource department with oversight/ responsibilities in areas of workforce regulations, training, and recruitment. The assessment team note this is not effectively managed at a service level in relation to staff attendance at training/education sessions or performance appraisal processes. [considered in requirements 7(3)(d) and (e)]. A new organisational system in relation to performance appraisal is being implemented at end of 2023. Organisational monitoring systems have not effectively identified lack of legislative requirements relating to restrictive practices [considered in requirement 3(3)(a)].

In their response, while the approved provider questions some evidence bought forward by the assessment team, they supplied an action plan to address deficits relating to lack of effective organisational governance systems at the service, including restrictive practices/regulatory compliance, information management and workforce governance. In consideration of compliance, while I accept organisational systems guide expectations, overarching monitoring systems have not been successful in identifying deficits at a service level; demonstrated by the approved providers response and commitment to reinstate/reintroduced organisation expectations. I consider it will take time to demonstrate effectiveness/sustainability of new processes, to ensure compliance with this requirement. I find requirement 8(3)(c) is non-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)