Performance

Report

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| 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: | 10 January 2024 to 11 January 2024 |
| Performance report date: | 8 February 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 D Saunders, 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 31 January 2024

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not fully assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not fully assessed** |
| **Standard 3** Personal care and clinical care | **Non compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable as not fully assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not fully assessed** |
| **Standard 7** Human resources | **Not applicable as not fully assessed** |
| **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 3(3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.
* Requirement 8(3)(c) Effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance, and feedback and complaints.

# 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. | Compliant |

Findings

The service was able to demonstrate consumers are supported to take risks to enable them to live the life they choose. Consumers described how they are supported to come and go from the service as they choose.

The Assessment Team observed consumers leaving the service independently, smoking cigarettes, and consuming foods not in accordance with their speech pathologist recommendations. Each of the consumer’s care documentation has evidence of the identification and assessment of the risk(s), mitigation strategies and the involvement of the consumer/representative.

Consumers interviewed by the audit team confirmed they had had discussions with staff regarding taking risks and the mitigation strategies around those risks.

For the above reasons, and in the absence of any adverse evidence, I find this requirement is 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. | Compliant |

Findings

Consumers/representatives expressed their satisfaction with the assessment and care planning delivered by the service.

Care documentation reviewed by the Assessment Team considers potential risks to consumers' health and well-being, including those with risk to skin integrity and those requiring pain management.

Care and clinical staff demonstrated an understanding of the service's processes for assessment and planning. Care plans are reviewed every three months or more frequently when individual needs change.

Care plan reviews include engagement with the consumers’ medical officer (MO) and allied health professionals as required to support the delivery of safe and effective care.

Prior to this audit the service was not compliant in this requirement due to consumer preferences not informing assessment and assessments not always being performed following changes circumstances.

The Assessment Team identified service remedial actions that addressed the historical deficiencies. Upon review of assessment and planning documentation for three named consumers and after speaking with those consumers, the team confirmed that assessment and planning was evident and properly informed care.

For these reasons I find this requirement 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. | Not Compliant |

Findings

At audit consumers and representatives interviewed were satisfied consumers are receiving care that is right for them, optimises consumers’ health and well-being and is in line with best practice.

Interviews with consumers/representatives and staff, and review of care/other documentation shows the service effectively manages most consumers' personal and clinical care.

The Assessment Team specifically reviewed several clinical areas, finding:

* Documentation for consumers consistently indicated that consumers skin integrity and wound care is tailored to their needs and optimises their health and wellbeing. Management said, staff confirmed, and documentation verified that the skin integrity of consumers is assessed on admission, reviewed each 3 months during the Consumer of the Day process, checked when a consumer returns from hospital and revised when there is a change in the consumers clinical condition.
* Consumers/representatives said that their pain is managed effectively. Clinical staff said they use a proprietary visual pain assessment program to assess the pain levels a consumer is experiencing. Clinical staff said, and documentation confirmed, that all consumers on Schedule 8 analgesia have a pain assessment each week. Staff said that when a consumer says they are in pain they are assessed, and the pain is managed using individualised strategies.

However, when assessing restrictive practice practices the Assessment Team found behaviour support plans did not always:

* contain evidence of assessments which have been carried out regarding behaviours,
* identify individualised triggers which may precede those behaviours,
* identify a range of alternative strategies which are known to be successful in managing those behaviours, and
* identify details of any restrictive practice used or applied once alternative strategies have been tried.

All staff interviewed were able to define restrictive practices, provide an outline of when it can be used and were able to summarise the processes to follow when restrictive practices are being used. No explicit issues of safety or effectiveness of care were found.

Despite this I consider that incomplete behaviour support plans means that care is not tailored and is less than best practice.

As these are the criteria under this requirement, I find 3(3)(a) to be non-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. | Compliant |

Findings

The service has a mix of a newer and older buildings, with some of the older building currently being renovated. Maintenance records and observations on site indicate maintenance (both preventative and corrective) and cleaning is carried out as scheduled.

Consumers and representatives interviewed consider the service is well maintained and cleaned.

Staff demonstrated a shared understanding of the elements of risk and safety about consumers residing in the secure area of the service being able to move freely outdoors, or being assisted to sit outside, when they desire to do so.

An electronic program is used to schedule and automatically assign preventative maintenance tasks to staff or contractors. The Assessment Team observed preventative maintenance documentation which recorded preventative maintenance tasks as up to date. The fire alarm system displayed no faults, and equipment was observed to be within maintenance date ranges.

Prior to this audit the service was not compliant in this requirement due to consumer dissatisfaction with cleaning, non-well maintained floor coverings, and some consumers were unable to freely move indoors and outdoors due to environmental restrictions.

These historical issues have been rectified and are no longer operative.

For the above reasons I find this requirement 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. | Compliant |

Findings

Overall, consumers/representatives expressed confidence the service uses feedback and complaints to improve the quality of care and services, and confirmed consumers are involved in improvement. Management advised the service analyses complaints, feedback and concerns raised by consumers/representatives and uses this information to inform continuous improvement activities across the service which are documented under the service’s plan for continuous improvement (PCI).

The Assessment Team reviewed the feedback and complaints register and the PCI. The PCI showed responses to complaints are used (where possible) to improve care and services.

Staff demonstrated a shared understanding of feedback and complaints processes.

For these reasons I find this requirement 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

In relation to requirement 7(3)(d):

This service was historically non-compliant in this requirement as it could not identify which mandatory training sessions were completed by staff or how this was monitored. This is a training deficit. No deficits relating to recruitment or support were noted.

In response to the identified deficit the service conducted mandatory training in late 2023 and introduced a series of toolbox talks. The training was across range of regulatory requirements and matters relevant to the quality standards.

Whilst this training was conducted, it was inadequately recorded. Accurate details of who had completed the training could not be provided to the Assessment Team.

In my view the deficit is better characterised as an information management or workforce governance deficit than as a training deficit.

I find requirement 7(3)(d) compliant. My assessment of requirement 8(3)(c) takes into account this assessment.

In relation to requirement 7(3)(e):

Management and staff demonstrated systems are in place to regularly assess, monitor, and review staff performance.

Staff confirmed at least annually they are provided an opportunity to discuss with service management their professional development and receive formal feedback.

Management reported, and the Assessment Team observed evidence confirming, all staff not on long term leave have completed performance appraisal in 2023.

Management said staff performance is monitored through observations, analysis of clinical data and consumer/representative feedback. When performance issues are identified, they are addressed immediately. To demonstrate this management provided documentation of a recent staff coaching session that was completed post medication incident.

For the above reasons I find requirement 7(3)(e) 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. | Not Compliant |

Findings

**Information management:**

Consumers and representative said, and documents confirmed, information is provided through consumer/representative meetings, newsletters, and email correspondence.

Also, a board member visits (at least annually) to communicate directly with consumers and staff at the service. The Assessment Team reviewed minutes from the 30 November 2023 Chief Executive Officer visit where consumers dined with the Board member and provided feedback for consideration directly to the Board.

Staff said to support the delivery of care and services, they are able to access consumer care details, policies, procedures, and training via the service’s electronic systems.

Neither paper-based nor electronic records could show which staff had attended mandatory training for 2023. In addition to this management were unclear of the current process for monitoring and reviewing staff compliance with training.

Management expects that the introduction of a new learning management system and other improvements will improve the governance information management.

**Continuous improvement:**

Management advised and review of the service’s PCI demonstrated, continuous improvement is identified via a variety of channels, including regular analysis of clinical and incident data, internal audits, complaint and feedback processes, at consumer/representative meetings and food focus groups. Information is collated by the quality team and relevant information is presented to the Board for review and feedback during Board meetings.

The service was audited against the Quality Standards by the Commission in May 2022 and July 2023. Deficits were identified. The service’s governance systems did not ensure a return to compliance, or ongoing compliance, with the Quality Standards.

This has resulted in the deficits remaining in the current report.

This establishes that effective governance processes for continuous improvement do not exist.

**Financial Governance:**

Management said, and the Assessment Team confirmed, the organisation’s executive team prepares and finalises a yearly budget and forecast. This includes review of consumer care needs and the workforce requirements.

The service manager provided the Assessment Team the service’s financial statement from 1 July 2023 which confirmed the service manager can make routine purchases within financial delegation to meet the changing needs of consumers. Staff reported they have sufficient equipment and stock to meet the needs of the consumers.

No deficits relating to financial governance were identified at audit.

**Workforce governance, including the assignment of clear responsibilities and accountabilities**

The organisation has a human resource and learning and development management team which has oversight in workforce regulations, training allocation, and recruitment.

However, at the time of the Assessment Contact management was unable to demonstrate to the Assessment Team effective processes are in place to ensure clear responsibility of management and staff in relation to allocation, monitoring, reporting and completion of mandatory training.

**Regulatory compliance**

Industry standards and guidelines are monitored by the organisation’s executive team through subscriptions to various legislative services and peak bodies. The organisation’s management keeps staff updated regarding any changes to legislation through staff meetings, toolbox sessions, and electronic messages to staff.

However, the organisation’s governance mechanisms which track, audit, and monitor compliance with legislative and regulatory standards have not ensured behaviour support plans reflect the needs of the consumer or statutory requirements. Behaviour support plans do not consistently include any assessments, identify known triggers or alternative strategies in managing those behaviours, and details of any restrictive practice used or applied once alternative strategies have been tried.

**Feedback and complaints**

The service demonstrated systems are in place to encourage and provide opportunity for staff, the consumer, and/or their representatives to provide feedback and complaints. The feedback and complaint register evidenced, and consumers said appropriate, timely action is taken when feedback and complaints are received. Feedback and complaints are considered for referral to the Board where appropriate.

Based on the deficits identified in information management, workforce governance, continuous improvement, and regulatory compliance – I find requirement 8(3)(c) non-compliant.

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