Performance

Report

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| Name: | Thomas Eccles Gardens |
| Commission ID: | 0197 |
| Address: | 26 Mount Street, YASS, New South Wales, 2582 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 26 March 2024 |
| Performance report date: | 6 May 2024 |
| Service included in this assessment: | Provider: 643 RSL LifeCare Limited  Service: 213 Thomas Eccles Gardens |

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 Thomas Eccles Gardens (**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 17 April 2024 and 23 April 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable as not all requirements have been assessed |
| **Standard 5** Organisation’s service environment | **Not Applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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. | Compliant |

Findings

The service has a policy for the management of skin integrity and wound care. Care and clinical staff have received education about pressure area care, pressure injuries and how to minimise skin damage, as well as training in wound care management. The care manager advised an incident report is generated when a wound occurs, a photograph is taken, and a wound assessment attended. Wound photographs are then attended at least weekly until the wound has healed. The service has access to a wound specialist for wound assessment and when clinical staff require extra guidance and support for wound management and care.

The service has several consumers who had experienced, or were at risk of, unplanned weight loss. Care and planning documentation show weight is regularly monitored, and those consumers identified as having lost weight are followed up with further investigations including food and fluid intake monitoring, referral to the medical officer, dietitian, and speech pathologist for review. Nutritional assessments, dietary preferences, and additional nutrition supplements were also noted.

The service has been actively working to minimise the use of psychotropic medications for consumers. This was evident through the review of consumers whose psychotropic medication has been ceased or changed as a result of regular reviews with the assistance of the consumer’s medical officer, the geriatrician, and external pharmacist medication reviews and others involved in consumer care. The service currently has consumers who have a chemical restraint and consumers with an environmental restraint. Review of the service’s psychotropic register showed all medications prescribed have corresponding consumer diagnoses and approved therapeutic use.

Care plans for personal care needs reflect consumer choice, and staff are aware of consumers’ individual needs and preferences. Personal care charts are maintained, including daily showers, continence care charts, oral hygiene charts, bowel charts, and repositioning charts. Consumers who have changed behaviours during personal and clinical care were assessed and monitored and have behaviour support plans in place. Strategies and interventions were trialled and used to minimise and reduce behaviours.

Consumers with specialised nursing care, including catheters and stomas, had care plans in place containing information related to device maintenance and replacement. Additional documentation, including wound charts, progress notes and catheter management charts, shows both catheters and stomas are monitored and maintained according to recommended practice and care directives.

However, the service is not consistently monitoring the safety and well-being of consumers who experience falls, with staff not consistently following the service’s policy and guidelines to optimise consumer health and well-being and to ensure best practice is implemented. Additionally, limited evidence was found to demonstrate staff undertook regular repositioning for a consumer post-surgery.

To guide staff in best practice care for consumers who experience a fall, the service has a falls management policy. In line with this policy, consumers who experienced falls were reviewed by their medical officer and the physiotherapist. The falls risk assessment tool was mostly observed to be updated by clinical staff and strategies and interventions updated where applicable. After consumers experience a fall, the policy states the frequency vital observations are to be conducted, however care planning documentation shows staff did not regularly follow these observation requirements.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions implemented to address the non-compliance including but not limited to, ongoing documentation education and training with staff, review and update of consumer care plans, pressure area care education and training provided to staff, and falls management training for clinical staff.

I acknowledge the findings of the Assessment Team, and the response provided by the Approved Provider. Although the Assessment Team identified areas for improvement, the service demonstrated it has implemented actions to address the Non-compliance and minimal impact was identified on consumers.

Based on the information provided by the Assessment Team and the Approved Provider, requirement 3(3)(a) is found 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

Feedback received from consumers and/or representatives indicated the service environment was clean and comfortable, with information and observations gathered to support this. The Assessment Team observed routes of egress to be clear, safety and exit signage working, emergency bags and fire extinguishers to be compliant. Consumer rooms, bathrooms, dining areas, corridors, pan room and outdoor areas were observed to be clean.

Staff described that maintenance requests are logged in the maintenance log folder located at the nurses’ station or they will verbally inform the maintenance officer. The maintenance officer described the reactive maintenance process and indicated he will check the maintenance log folder each morning to check what needs to be fixed. However, for verbal maintenance requests received from staff, the maintenance officer indicated that he would record them in his notebook, and these verbal requests would not be logged in the maintenance log folder.

The service has one maintenance officer and if they are absent or on leave, the service is supported by the organisation’s neighbouring independent living maintenance officer for any urgent maintenance issues. The facility manager indicated they have a weekly meeting with the maintenance officer to keep up to date on maintenance issues.

However, deficits were identified in relation to the service environment being safe and well maintained. The Assessment Team identified areas for improvement in relation to preventative maintenance, the fire safety statement, outdated fire evacuation diagrams, and review of the emergency management plan.

The Approved Provider responded with additional documentation to demonstrate compliance with this Requirement and included a plan for continuous improvement containing actions taken to address the Non-compliance, including but not limited to consulting an external fire safety specialist for evacuation guidance, updating evacuation diagrams, ongoing weekly meetings to occur between the facility manager and the maintenance officer to discuss any maintenance issues.

I acknowledge the findings of the Assessment Team, and the response provided by the Approved Provider. Although the Assessment Team identified areas for improvement, the service demonstrated it has systems in place to manage the deficiencies and no impact were identified on consumers.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 5(3)(b) is found Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Consumers and/or representatives stated the service responds quickly to complaints raised and followed an open disclosure process when required. Staff described the complaints process and how to report and escalate complaints using internal processes. Management provided evidence of correspondence and outcomes in regard to complaints and feedback and demonstrated open disclosure processes occurred when managing complaints and incidents.

The service has policies and procedures guiding staff on feedback and complaints handling, as well as on open disclosure. Staff described the complaints handling process, including the need for feedback, issuing an apology, and development of strategies to address the compliant. Registered nurses understood open disclosure and were able to describe examples when they used this process after complaints or incidents occurred.

Whilst verbal evidence from consumers, representatives and staff confirmed management and staff were responding to complaints, practicing open disclosure when required, and making appropriate changes to address issues, in some cases documented evidence was lacking to confirm these details. Management and staff acknowledged verbal complaints were not listed in their register if they could be resolved immediately and staff confirmed they lacked training in recognising when feedback needed to be documented as a complaint. The lack of documentation around complaints meant management was unable to accurately trend issues, put in place improvements to address trends, and monitor the success of improvements.

The Approved Provider responded with additional documentation to demonstrate compliance with the Requirement and included a comprehensive plan for continuous improvement.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 6(3)(c) is found 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)