Performance

Report

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| Name: | Torrens Valley Aged Care |
| Commission ID: | 6138 |
| Address: | 2 Albert Street, GUMERACHA, South Australia, 5233 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 27 August 2024 |
| Performance report date: | 23 September 2024 |
| Service included in this assessment: | Provider: 9695 Barossa Hills Fleurieu Local Health Network Incorporated  Service: 4155 Torrens Valley Aged Care |

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 Torrens Valley Aged Care (the service) has been prepared by Micheal Cooper, 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 10 September 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all Requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not 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)(b) – The approved provider must implement a process to monitor and effectively manage risks associated with the care of consumers. Specifically, the management of consumers with a diagnosis of diabetes, and consumers who are subject to restrictive practice.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Consumer’s advised staff involve them in their plan of care and discuss their goals, needs, and preferences. Service documentation evidenced care and service plan processes including 6 monthly care and service plan reviews. Care documentation evidenced regular and ongoing care and service plan reviews when incidents occur and as circumstances in care needs change.

In coming to my decision for this Requirement, I have considered the information outlined in the assessment contact report, and I have place weight on processes and documentation evidencing the service is ensuring care and service plans are reviewed regularly for effectiveness.

It is my decision Requirement 2(3)(e) is Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |

Findings

Care documentation evidenced staff are not effectively responding to consumer’s diabetic management needs. Care documentation for three consumer’s demonstrated multiple instances where blood glucose levels (BGLs) were recorded outside of safe parameters, and despite diabetic management plans outlining escalation protocols, the service could not evidence action staff had taken to support consumers.

The assessment contact reports where restrictive practice is implemented, consent is not always recorded by a medical practitioner, and where behaviour support plans (BSPs) are in place they lack personalised support strategies to guide staff in the delivery of care and services.

In relation to diabetic management, the approved provider’s response outlined actions it has taken to remediate the deficiencies including a review of all diabetic management plans and education provided on 4 September 2024 in relation to diabetic management protocols. The approved provider’s response outlines the service is now utilising standardised guidelines to ensure where BGLs are recorded outside of target parameters the issue is escalated to a medical practitioner to guide safe care delivery.

In relation to restrictive practice, the approved provider’s response acknowledged feedback provided by the assessment team and explained the service is actively working with medical practitioners within the service to ensure compliance with its obligations under the Quality Principles. The approved provider advised the service is revising all BSPs to ensure they are specific and personalised to each consumer.

In coming to my decision for Requirement 3(3)(b), I have considered the information provided in the assessment contact report and approved provider’s response. I acknowledge the actions the approved provider has taken and plans to take to remediate the deficiencies identified, however I am of the view that the actions being taken by the service will take some time to be fully implemented and evaluated for effectiveness. I have placed weight on care and service documentation provided demonstrating where BGLs are recorded outside of target parameters, there is not always a safe and effective response to support consumers. Where restrictive practice is implemented, consent is not always recorded, and consideration of associated risks are not always evaluated.

It is my decision Requirement 3(3)(b) is Not Compliant.

The assessment contact report outlines one consumer representative interviewed was satisfied with the end of life care their loved one has recently received. Service documentation evidenced policies and processes in place for staff to be guided by in the provision of end of life care, including emergency response and escalation protocols. Training records demonstrated staff have received education in relation to palliative care. Care documentation evidenced staff are identifying and recording consumer’s goals, needs, and end of life preferences to ensure their dignity and choices are maintained.

In coming to my decision for this Requirement, I have considered the information outlined in the assessment contact report, and I have placed weight on the positive feedback provided by representatives, and processes in place to ensure consumers have their end-of-life goals identified and addressed to maximise their comfort and maintain their dignity during end-of-life care.

It is my decision Requirement 3(3)(c) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Consumers and representatives provided positive feedback in relation to consumer care and services, and said staff respond to their call bells in a timely manner to meet their care needs. Staff explained the service ensures there is enough staff to meet consumers' care needs. Service documentation evidenced call bell monitoring processes in place with trends identified to guide and inform improvements.

In relation to the workforce responsibilities (including the 24/7 registered nurse) requirement and mandatory care minutes, the service’s roster and interviews with management evidenced the service is meeting their care minute target, however there is not currently a RN rostered on site and on duty at the service 24 hours per day, across 7days of the week. The assessment contact report demonstrates the service is collocated with an acute hospital and health service and support is provided to clinical staff through this service when a RN is not rostered within the aged care home.

I have considered the information within the assessment contact report, and I have placed weight on the information including the positive feedback from consumers and representatives interviewed and processes in place to ensure sufficiency of staff to meet consumer’s care needs.

It is my decision Requirement 7(3)(a) is Compliant.

Consumers and representatives provided positive feedback in relation to the delivery of care and services and said staff are competent and their care needs are met. Training records evidenced staff have received education to perform their job roles. Whilst the assessment contact reports approximately 70 percent of the workforce have attended their mandatory training, the service evidenced communication to staff with overdue education to ensure all staff are up to date with their mandatory training obligations. Staff explained they feel supported and equipped to perform their job requirements.

In coming to my decision for this Requirement, I have considered the information outlined in the assessment contact report, and I have placed weight on the positive feedback provided by consumers and representatives, and processes in place to ensure the workforce is competent to effectively perform their job roles.

It is my decision Requirement 7(3)(c) is Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

The service evidenced an effective risk management system in place to guide staff in the delivery of care and services. The service’s governing body demonstrated knowledge and awareness of its obligation in responding and reporting incidents including incidents under the serious incident response scheme (SIRS). Service documentation evidenced policies and procedures to guide staff in managing high impact and high prevalence risks, responding to incidents of abuse and neglect, and managing and preventing incidents. Service documentation evidenced incident analysis, with identified trends and actions implemented to support continuous improvement. Staff were aware of its obligations in reportable incidents and demonstrated knowledge of the service’s incident response procedures.

In coming to my decision for this Requirement, I have placed weight on the information provided in the assessment contact report, and I have considered evidence of processes and systems in place to guide staff in identifying and reporting risk to inform continuous improvement actions.

It is my decision Requirement 8(3)(d) is 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)