Performance

Report

**1800 951 822**

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| Name of service: | Uniting Koombahla Elermore Vale |
| Service address: | 138 Lake Road ELERMORE VALE NSW 2287 |
| Commission ID: | 0423 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 June 2023 |
| Performance report date: | 14 July 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 Uniting Koombahla Elermore Vale (**the service**) has been prepared by P. Sherin, 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 4 July 2023 acknowledging the assessment team’s findings and providing additional information.
* the site audit report for the site audit conducted 02 August 2022 to 04 August 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **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 taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 02-04 August 2022.

The service was able to demonstrate provision of personal and clinical care in accordance with consumers’ preferences and needs. Consumers said they were satisfied with provision of personal and clinical care which is provided in a timely manner. Review of care planning documentation identified information to guide staff practice in the delivery of care such as interventions for pain, falls, and behaviour management which were found to be effective. Staff were aware of individual consumers’ personal preferences and were able to describe strategies implemented in care delivery which aligned with information under consumers’ care planning documentation. The service implements a psychotropic register which accurately identifies consumers subject to chemical restrictive practice. Where restrictive practices are in use, documentation evidenced appropriate authorisations, behaviour support plans, monitoring and review in place.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate each consumer was receiving safe and effective personal and clinical care tailored to their needs and in line with best practice to optimise their health and wellbeing. The service was unable to demonstrate how they manage risks associated with chemical restrictive practice.

The service has implemented the following improvement actions to remediate these deficits:

* A review of all consumers’ care plans to ensure their personal preferences are documented and care and services are tailored to individual needs. Care staff are provided with a handover sheet each shift and any changes in consumer needs are recorded.
* A review of all consumers subject to restrictive practices at the service to ensure consent authorisation forms are in place. Review of the service’s psychotropic register and chemical restrictive practice folder confirmed this has occurred.
* Provision of training to staff on dementia via online training modules and face to face sessions delivered by an external dementia specialist service. Interviews with management and care staff and review of documentation confirmed this has occurred.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement 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 |

Findings

The service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 02-04 August 2022.

The service demonstrated an adequate workforce is in place to enable the delivery and management of safe and quality care and services. Consumers and representatives expressed satisfaction with staff numbers, confirming consumers are attended to promptly, and staff are available when needed. Staff reported they generally have enough time to complete their allocated tasks and to provide consumers with regular care in accordance with their preferences. Management described various strategies in place to avoid staffing shortfalls, including extending and adding additional shifts to the roster and engaging agency staff where required. Review of recent rosters identified the service replaces staff on unplanned leave. The assessment team observed staff available and attending to call bells in a timely manner during the assessment visit.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate sufficient staff to ensure the delivery and management of safe and quality care and services. The service has implemented the following improvement actions to remediate these deficits:

* Additional hours allocated for care staff during morning and afternoon shifts each day.
* An increase to the number of registered nurses with 3 nurses allocated each morning shift, 2 nurses for the afternoon shift, and one at night who is occasionally supported by a second registered nurse. The service provides registered nurse coverage 24 hours a day, 7 days a week.
* Management advised rosters are scheduled 2 weeks in advance with staff provided regular rostered shifts based on their preferences and availability. Rosters are designed to provide optimal coverage at times when consumers require support with their care needs and preferences. Staff have been instructed to stagger their breaks to provide optimal coverage.
* A small pool of casual staff has been employed to provide flexibility when short notice absences impact the workforce schedule. Management meets with staff regularly to identify any absences, staffing requirements, and organise replacement as required.
* The service has implemented new processes for call bell review and analysis since September 2022. A memo is circulated twice a month instructing homemaker staff to audit call bell registers within their residential wing and identify consumers experiencing wait times of more than 10 minutes. Homemaker staff meet with each consumer to provide an apology for the delay. Staff identified as contributing to delayed call bell responses are provided a toolbox talk on the importance of timely call bell response and suggestions on minimising wait times. Review of call bell reports and audits identified this process is occurring and has led to improvements in call bell response times.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement 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)