Performance

Report

**1800 951 822**

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| Name of service: | Uniting Osborne Nowra |
| Service address: | 54-60 Osborne Street NOWRA NSW 2541 |
| Commission ID: | 2556 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 August 2023 to 16 August 2023 |
| Performance report date: | 21 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 Uniting Osborne Nowra (**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.
* Approved provider’s response acknowledgement of report received on 8 September 2023
* Performance Report dated 13 September 2022

# 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 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

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 to remain compliant with the Quality Standards.

# 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 |
| 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

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

A decision made on 13 September 2022 found non-compliance in requirements 2(3)(a) and (e) after a site audit contact visit 27-28 June 2022 and 25-28 July 2022.

Requirement 2(3)(a)

Previously the service was non-compliant as they did not demonstrate risks are considered in assessment and planning to inform delivery of safe/effective consumer care and reassessment occurs following incidents. In response, as per the service’s plan for continuous improvement (PCI) they reviewed consumers to update assessments particularly relating to continence, skin integrity, and mobility. Case conference meetings/discussion with consumers/representatives occurred including offering of care planning documentation, and provision of staff training relating to continence management.

During this assessment contact information was gathered through interviews, observations, and document review. Effective systems demonstrate partnership with consumers/representative’s and ensures assessment/planning considers risks to consumers health and wellbeing. Sampled consumers/representatives consider regular consultation occurs regarding risks consumers wish to take and they have access to care plans. Identified risks are documented to guide staff and processes prompt identification/interventions/minimisation of risks to inform delivery care. Reviewed documentation reflect details to consumers health and well-being and interviewed staff describe process for identifying risks, management of same and specific details relating to individual consumers’ needs. A suite of policies/procedures guide staff in assessment and care planning requirements and organisational multidisciplinary team members assist with strategies/interventions when needed.

Requirement 2(3)(e)

Previously the service was found non-compliant as they did not demonstrate follow-up processes to understand causal factors of incidents informs ongoing care and/or review of interventions to determine effectiveness and prevent possible future incidents. In response, as per the service’s PCI, they reissued staff guidance relating to management of falls, registered nurses participated in clinical governance education/training including falls management, reviewed pain assessment and incident reporting/monitoring processes to ensure appropriate completion of documentation.

During this assessment contact information was gathered through interviews, observations, and document review. Organisational expectations guide regular review of consumers to ensure appropriate care provision meets individual needs when incidents occur and/or circumstances change. Sampled consumers express satisfaction of involvement/discussion relating to their individual needs. Consumers/representatives participate in assessment/care planning with registered nurses, medical officer/allied health/specialists to determine agreement in care provision. Interviewed staff demonstrate knowledge of reporting/management processes giving examples of changes in consumers’ needs when incidents occur. Management team monitor and review reported incidents, conduct daily staff meetings to discuss care needs and ensure timely referral to medical officer/allied health/specialists. Incident review informs continuous improvement activities as a means to attain positive outcomes. Electronic documentation systems alert staff to consumers changed needs, and incident analysis/trending occurs. Staff receive ongoing education/training. File review detail documented changes in care requirements and strategies for positive outcomes post incident.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The Quality Standard was not fully assessed; three of seven requirements were assessed and found compliant.

A decision was made on 13 September 2022 the service was non-compliant in requirements 3(3)(a), (b) and (f) after a site audit contact visit 27-28 June 2022 and 25-28 July 2022.

Requirement 3(3)(a)

Previously the service was non-compliant as they did not demonstrate each consumer receives safe/effective personal and clinical care is per principles of best practice, individualised and optimises health and well-being. In response, as per the service’s PCI they reviewed diabetes monitoring processes; met with registered nurses relating to clinical issues, provision of clinical guidelines and education, daily monitoring by management to ensure compliance, comprehensive file review to ensure appropriate documentation, implementation of escalation process/audit of wound management documentation and review of care planning directives.

During this assessment contact information was gathered through interviews, observations, and document review. Sampled consumers/representatives gave positive feedback regarding clinical/personal care expressing satisfaction staff provide safe/appropriate care to meet consumer’s individual needs. Documentation demonstrates care tailored to consumers specific needs/preferences. Observation of staff practices relating to monitoring/management of falls, pain, weight loss, wound/skin integrity and specialised nursing care are consistent with best practice and organisational guidelines. Clinical policies/procedures guide staff, who advise receipt of education/training supports care provision, and registered nurses receive training relating to best practice clinical care. Documentation review detail appropriate consent/regular review processes relating to psychotropic medication, trial of alternative methods of pain relief prior to administration of medication, strategies to prevent and/or respond to deterioration of existing pressure injuries, and adherence to directives relating to diabetes management.

Requirement 3(3)(b)

Previously the service was found non-compliant as they did not demonstrate investigation into cause of high impact/prevalence risks to reduce prevalence of re occurrence. In response, as per the service’s PCI actions include clinical governance meetings, monitoring of falls to ensure compliance with organisational expectations and reporting within incident management system.

During this assessment contact information was gathered through interviews, observations, and document review. High impact/high prevalence risks are managed through clinical governance recording and management systems which identify/manage/monitor risks, documentation review detail positive consumer outcomes. Effective management of risks relating to falls, pain, responsive behaviours, pressure injuries and wound management is evident; relationship between pain and responsive behaviours is considered/addressed. Management and staff demonstrate knowledge of high impact/prevalence risks for individual consumers and at service level, providing differing strategies trialled to minimise and/or prevent risk. The assessment team observe reporting/responding/analysis and trending of incident reporting occurs.

Requirement 3(3)(f)

Previously the service was found non-compliant as they did not demonstrate consumers are referred to providers of other care and services in a timely manner. In response, as per the PCI the service introduced documentation/processes to track consumers’ appointments to medical/allied health specialists to ensure timely response.

During this assessment contact information was gathered through interviews, observations, and document review. Timely and appropriate referrals to individuals and other organisations/providers of care and services occurs. Management and registered nurses demonstrate knowledge of processes relating to referrals, including multiple specialists/services available to support care. Interviewed staff demonstrate knowledge of referral processes including communicating resulting care changes. Recording and monitoring processes ensure timely referral responses and subsequent directives/outcomes are included in care documentation to guide staff in current requirements. Documentation details regular review, subsequent strategies/directives and current needs documented to guide staff in care delivery.

# 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. | Compliant |
| 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 Quality Standard was not fully assessed; two of five requirements were assessed and found compliant.

A decision made on 13 September 2022 found non-compliance in requirements 8(3)(c) and (d) after a site audit contact visit 27-28 June 2022 and 25-28 July 2022.

Requirement 8(3)(c)

Previously the service was found non-compliant as they did not demonstrate effective organisation wide governance systems relating to regulatory compliance particularly management of restrictive practices. In response, as per the service’s PCI they updated restrictive practice policies/procedures, improved communication/monitoring, and oversight processes to ensure staff practice aligns with organisational expectations/legislative requirements.

During this assessment contact information was gathered through interviews, observations, and document review. Effective organisational governance systems include monitoring and oversight processes to ensure compliance. Information management systems include incident, hazard and complaint reporting, communication of risks, and governing body guidance regarding reform and organisation priorities. A process ensures information is regularly provided from organisational personnel to consumers/representatives and staff. Review of documentation and interviews demonstrate the organisation identifies areas for improvement from a variety of sources developing action plans for implementation/monitoring. Processes for oversight of service budget/approval of funds to support consumer well-being is evident. Service management has delegation to approve expenses and referral to organisation team when required. Effective oversight and governance systems ensure appropriate numbers and skill level relating to workforce including a crisis management office to address ongoing workforce challenges. Policies and procedures outline governing body responsibilities and accountabilities. Organisational personnel provide governance and oversight of aged care reforms; information is communicated via monthly quality forums. Multiple avenues are available for consumers/representatives and staff to provide feedback and complaints to inform improvement. Development of a consumer advisory body is in progress to enable feedback and engagement in tailoring services to meet their needs and wishes.

Requirement 8(3)(d)

Previously the service was found non-compliant as they did not demonstrate effective risk management systems and practices, relating to high impact and high prevalence risks.

During this assessment contact information was gathered through interviews, observations, and document review. Effective systems ensure implementation of organisational risk management practices and governing body oversight to ensure service compliance with expectations and reporting to regulatory bodies. Updated policies/procedures and improved communication, monitoring and oversight processes relating to restrictive practices ensures staff practice aligns with organisational expectations. Policies/procedures guide staff relating to incident management, outlining responsibilities in prevention/responding to consumer abuse and neglect. Documentation review and interviews with management demonstrate oversight to monitor/manage high impact/prevalence risks at individual level and service-related risks. Electronic alerts ensure staff awareness leads to appropriate care addressing consumers individual needs. Review of processes following incidents occurs to identify continuous improvement activities and/or prevent reoccurrence. Effective use of incident management systems, including reporting to organisational governing body occurs. Processes (including monitoring/organisational oversight) support consumers to live their best life.

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)