Performance

Report

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| Name of service: | Vietnam Veterans Keith Payne VC Hostel |
| Service address: | 1 Evans Road NORAVILLE NSW 2263 |
| Commission ID: | 0309 |
| Approved provider: | Alino Living |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 June 2023 to 7 June 2023 |
| Performance report date: | 10 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 Vietnam Veterans Keith Payne VC Hostel (**the service**) has been prepared by S Turner, 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 30 June 2023
* the Performance Report dated 14 July 2022 for the Site Audit conducted 31 May 2022 to 2 June 2022

# 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** |
| **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 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 |
| 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 |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-compliant in Requirements 3(3)(a), 3(3)(c) and 3(3)(g) following a Site Audit conducted 31 May 2022 to 2 June 2022. Deficiencies included:

* The service was unable to demonstrate aspects of care delivery were best practice including pain management and end of life care.
* Some practices were not consistent with effective minimisation of infection related risks.

The service had initiated a number of improvements to improve its performance in relation to Requirements 3(3)(a) and 3(3)(c) following the Site Audit:

* Staff had received training in documentation and pain management and two registered nurses had completed palliative care training. Staff demonstrated a sound knowledge of pain management and end of life care and how to apply this in care delivery.
* Competencies in the use of palliative care equipment such as syringe drivers had been completed by a number of registered nurses who reported they felt confident as a result of the training; newly appointed registered nurses had six months to complete the competency.
* The heat pack policy had been revised by management and the physiotherapist.
* Management staff said they had communicated with registered nurses in relation to the documentation associated with the use of ‘as required’ analgesia.
* The service audited and monitored the use of ‘as required’ analgesia and those consumers with a high level of administration were reviewed to identify opportunities in pain management.
* All consumers’ pain risk scores were reviewed and pain risk scores were included in the four monthly care plan review cycle.

While the Assessment Team identified deficiencies in the documentation of aspects of clinical and personal care including for example fluid intake, pressure area care and monitoring of restrictive practices, staff reported that they completed these tasks and the Assessment Team found there had been no negative outcomes experienced by consumers. Management actioned this during the Assessment Contact, emailing staff with information about the actions required to meet organisational expectations.

Overall, the service demonstrated timely identification and effective assessment, management and evaluation of consumers’ personal and clinical care including in relation to skin integrity, pain, weight loss, continence care and diabetes management. The needs, goals and preferences of consumers nearing end of life were recognised and addressed with the service taking action to promote the consumer’s comfort and dignity. Consumers and representatives were generally satisfied with the care they received and representative feedback relating to end of life care was positive. They provided feedback that staff do their best to manage consumers’ pain, that the consumers were monitored when their condition changed and when necessary were transferred to hospital. A representative for a deceased consumer said staff were ‘lovely and amazing’ and were ‘kind and caring’. Another representative stated staff were proactive in managing the consumer’s pain, they provided analgesia as required and delivered care in accordance with the consumer’s preferences.

The service had policies and procedures which guided clinical practice to support the delivery of personal and clinical care and assessment and care planning processes were generally in place and reflected consumers’ care needs. An end of life pathway was established but at the time of the Assessment Contact had not been implemented; management reported that the service was progressing towards implementation. A palliative care service was engaged when required to ensure consumers’ pain was minimised and they were provided with appropriate comfort care.

Staff demonstrated an understanding of pain management, the use of pharmacological and non-pharmacological pain management interventions, and could describe how it was being provided to individual consumers. Registered nurses reported increased confidence in relation to managing consumers’ pain and said they had received education to improve their understanding of best practice pain management, including palliative care, the use of ‘as required’ analgesia and the associated documentation.

Registered staff said they discussed consumers’ end of life preferences during case conferences and as the consumers moved through the palliative care phases. Staff said they monitored consumers for comfort and followed care plans for guidance in relation to individual consumer preferences.

The Assessment Team reviewed the care of consumers with chronic and complex health conditions and those with specialised nursing care needs and found they received care that was tailored to their needs. Where consumers had experienced a deterioration in their health this was escalated appropriately and in a timely manner. A review of care delivered to consumers who were at the end of life and who have since died demonstrated the administration and evaluation of prescribed medications for symptom management. Comfort cares were delivered and documentation demonstrated the service delivered care in accordance with the consumer’s advance care directive.

The approved provider in its response received 30 June 2023 to the Assessment Team’s report addressed the deficiencies brought forward by the Assessment Team in relation to documentation. It stated the following actions had occurred and submitted detailed evidence to support this:

* The heat pack policy was revised and has been distributed to staff. The revised policy states heat packs should not be used on consumers who have cognitive impairment and staff meetings have been used to disseminate information about safe use of heat packs.
* Care plans for consumers with a cognitive impairment have been reviewed in relation to the use of heat packs and an audit was conducted and confirmed that heat pack usage was appropriate and in accordance with organisational guidance.
* Care staff were reminded of their documentation responsibilities associated with the provision of daily care tasks and the service has implemented strategies to monitor staff compliance that included supervision by registered nurses. A review of consumers’ planned day tasks is being completed to ensure an increased focus on the completion and documentation of critical care tasks.
* With respect to documentation associated with diabetes management, consumers’ fluid intake, complex care delivery and the end of life pathway; the service has reviewed the care of consumers to ensure documentation is in place to guide staff. Staff education has occurred, colour coded equipment purchased to discreetly identify consumers on fluid restrictions at mealtimes and monitoring processes implemented to ensure staff compliance.
* An audit was completed for those consumers who have a mechanical restraint authorised as an element of their care, to ensure monitoring checks were scheduled at the appropriate frequency. Audit results demonstrated frequency of monitoring was correct for each consumer. Additional monthly audits and indicators relating to the use of restrictive practices have been added to monthly reporting.

I am satisfied, that overall consumers were receiving care that was tailored to their needs and optimised their health and well-being. For those consumers who were nearing end of life, their needs and preferences were addressed and their comfort was maximised. Additionally, consumers and representatives generally spoke positively about the care provided to consumers. The approved provider has actively addressed deficiencies brought forward by the Assessment Team and provided evidence that has persuaded me that these improvements will be embedded into staff practice.

For the reasons detailed, I find Requirements 3(3)(a) and 3(3)(c) are Compliant.

The Assessment Team found that the service had initiated a number of improvements under Requirement 3(3)(g) in relation to infection control following the Site Audit; these included:

* Staff had received education and training in infection control including in relation to hygiene, the use of personal protective equipment, transmission, and isolation precautions. Staff confirmed they had completed education in these areas and could describe the relevant practices.
* Management advised an audit was completed to identify all consumers requiring slings (for transfer) and had provided named/labelled slings to those consumers who required them.
* Additional hand hygiene stations and glove racks were installed.
* Two clinical staff were completing the Infection Prevention and Control lead training.

However, the Assessment Team brought forward information demonstrating ongoing deficiencies in some staff practices relating to infection control and actions implemented to improve performance in this area had not been consistently effective. For example:

The Assessment Team observed:

* staff not complying with personal protective equipment requirements and hand hygiene
* screening processes on entry to the service were not consistently applied, and
* staff did not have a shared understanding in relation to the use of shared equipment, for example, slings.

The approved provider’s response to the Assessment Team’s report in relation to 3(3)(g) was comprehensive and included evidence demonstrating that improvements made following the Assessment Contact have resulted in improved outcomes in infection control. For example:

* Organisational expectations regarding infection control have been communicated through the implementation of new policies, staff emails and mandatory staff meetings.
* Staff have received additional information and education reminding them of their responsibilities in relation to infection control including in relation to the management of consumers who are isolating; screening processes (for staff who were in that role); sling usage; and hand hygiene.
* Increased monitoring by the corporate Infection Prevention and Control lead have been conducted that included observation of staff practice, education audits, equipment audits and infection control audits. Audit results were submitted as an element of the response and demonstrated marked improvements in staff compliance with infection control including in relation to hand hygiene, entry screening processes, sling usage, donning and doffing, environmental precautions, and isolation precautions .
* Equipment and resources have been purchased including additional slings (so that each consumer now has two slings) and additional hand sanitizer stations.
* Hand hygiene and personal protective equipment competencies were re-commenced.
* The corporate Infection and Prevention Control lead has been attending handover on a daily basis to discuss infection control with staff, including the outcome of infection control audits.
* One on one education was conducted as a need was identified.
* The frequency of internal infection control observation audits has increased in frequency to quarterly.

I have carefully considered the Assessment Team’s report and the approved provider’s response. I am persuaded that Requirement 3(3)(g) is Compliant as significant improvements in staff practice have been achieved through education, supervision, and monitoring; and evidence of this was provided.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was found Non-compliant in requirement 7(3)(e) following a Site Audit conducted 31 May 2022 to 2 June 2022 as regular performance reviews for each member of staff were not undertaken.

The service had implemented a new paper based performance assessment tool; this was developed and was in use as an interim tool however ongoing deficiencies remained in this requirement with some staff not having had a performance review completed within the previous 12 months.

Staff provided mixed feedback in relation to the performance review process with some staff reporting they had undertaken a performance review in late 2022 and other staff stating they had not had a performance review completed in the previous 12 months.

The service has a performance management procedure in place and a performance register; the Assessment Team identified the performance register was incomplete and failed to record all members of staff. This was confirmed by management who reported there were outstanding performance reviews to be completed; they committed to addressing this within the following two weeks.

The approved provider in its response to the Assessment Team’s report stated the performance appraisal policy has been reviewed, updated, and distributed to staff. The performance appraisal register has been updated and now includes all staff; and all outstanding performance reviews have been completed. The performance appraisal register was submitted by the approved provider and demonstrated that performance appraisals have been completed and are being tracked. A register has been commenced at an organisational level to improve governance relating to the service’s completion of performance appraisals. An additional monthly audit and clinical indicators have been added to the high impact high prevalence risk report to oversee completion of performance appraisals. Reporting is scheduled to commence in June 2023.

I have carefully considered the Assessment Team’s report and the approved provider’s response. The approved provider has submitted detailed information as an element of its response demonstrating that there are processes in place to ensure regular review of staff performance. I am satisfied Requirement 7(3)(e) is 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. | 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 service was found Non-compliant in requirements 8(3)(c) and 8(3)(d) following a Site Audit conducted 31 May 2022 to 2 June 2022. Deficiencies related to information systems, workforce governance and risk management practices.

The Assessment Team’s report includes information demonstrating the service has initiated a number of improvements following the Site Audit to improve its performance in relation to Requirements 8(3)(c) and 8(3)(d); actions include:

* Staff have received education and training including in relation to documentation, compliance systems, infection control and pain management.
* Two registered nurses have completed palliative care education.
* Two staff are completing Infection Prevention and Control lead training.
* Competencies in the use of equipment to support symptom management in palliative care, have been completed by registered nurses, with newly recruited registered nurses provided with a six month window to complete.
* Policies have been revised for example the Nutrition policy and the Heat Pack policy.
* Clinical information is monitored and audited to identify opportunities to improve care delivery; for example, the use of ‘as required’ analgesia.
* Introduction of a high risk consumer whiteboard in the nurses’ stations and a seven days per week registered nurse handover system. Staff reported the whiteboards were an effective guide in supporting them to understand any changes in consumers’ care needs.

The Assessment Team identified some deficiencies in care related documentation, the approved provider has taken action to remediate these deficiencies and evidence of this was included in the approved provider’s response.

Staff reported information was readily available and accessible through the organisation’s information management system and that this assisted them in undertaking their role. The electronic care management system provided staff with levels of access to consumer care planning documentation that was relevant to their role. Staff had access to up to date policies, procedures, and training and this was available through the service’s electronic systems. Consumers and representatives were satisfied with the way information about care and services was managed and how they were provided with information.

Management advised continuous improvement opportunities were identified through a range of sources including consumer and representative feedback, audit and survey results, clinical indicator data and critical incident data. A plan for continuous improvement was in place and demonstrated that improvements had been initiated.

Management could describe how they sought changes to the budget or to expenditure to support consumers’ changing needs. A yearly budget was prepared and financial delegations were in place.

There were processes to track, monitor, and audit compliance with legislative and regulatory standards. Industry standards were monitored by the organisation’s executive team through subscriptions to various legislative services and peak bodies. The organisation communicated changes to legislation through staff meetings, toolbox sessions, electronic messaging to staff, and monthly newsletters.

Consumers and representatives were encouraged to provide feedback and make complaints although the Assessment Team identified that in some instances feedback had not been documented. Some staff said they do not always document or record verbal feedback if they can manage the situation and resolve the concern. Management explained the complaints policy which demonstrated staff were following organisational processes to resolve minor complaints.

While deficiencies were brought forward in relation to performance review processes the approved provider’s response demonstrated improvements had been initiated and processes were in place to ensure staff completed their performance reviews. Additionally, mandatory training was provided and this was tracked through a training register; position descriptions and duty statements were documented for each position. I am satisfied there are processes to support workforce management.

I am satisfied there are effective organisation wide governance systems in place and that Requirement 8(3)(c) is Compliant.

The service was able to demonstrate that effective risk management systems and processes were in place. There were policies describing how to manage high impact and high prevalence risks; respond to abuse and neglect; support consumer choice and decision making; and manage and report incidents including incidents relating to the Serious Incident Response Scheme. Additionally, there were updated policies relating to clinical risk management, smoking and nutrition. Staff were aware of these policies and could describe how they applied to their role in a practical way. Management advised that incidents were recorded within the service’s electronic care management system, investigated and actions implemented to prevent a reoccurrence. Management described the systems in place to identify, manage and monitor risks including falls, skin integrity, pressure injuries and medication errors.

I am satisfied effective risk management systems and processes are in place and find 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)