Performance

Report

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| Name of service: | Villa Dalmacia Aged Care Facility |
| Service address: | 27 Gorham Way SPEARWOOD WA 6163 |
| Commission ID: | 7234 |
| Approved provider: | Villa Dalmacia Association Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 12 April 2023 |
| Performance report date: | 4 May 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 Villa Dalmacia Aged Care Facility (**the service**) has been prepared by K Richards, 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.

# 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 consumers, representatives, staff, management and others;
* the Performance Report dated 9 June 2022 for the Site Audit conducted on 29 March 2022 to 31 March 2022; and
* the provider’s response to the Assessment Team’s report received 26 April 2023.

# 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 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 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 |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 29 March 2022 to 31 March 2022, where it was found the service was not using assessment and planning to inform delivery of safe and effective care and services in relation to pain management, falls, wound care, diabetes management and monitoring for fluid overload for consumers at risk. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the pain management policy, developed a flowchart for pain assessment, and purchased validated electronic pain assessment software. Staff were provided education on pain management and process changes.
* Reviewed policies relating to falls and fall management, developed a flow chart on prevention of falls, and provided staff education on changes. The incident form has been updated to prompt pain charting and monitoring.
* Reviewed the wound management policy and engaged a wound specialist for 12 months, undertaking a wound project, provided staff education and reviewing wound data monthly.
* Electronic devices and software were purchased for timely staff documentation and improved monitoring.
* Reviewed consumers requiring fluid management, updating the nutrition and hydration assessment to include fluid balance monitoring and directives, and adding alerts to written handover processes.

The Assessment Team was satisfied these actions and improvements were effective. Sampled consumers were monitored for pain following incidents, with their representatives satisfied with pain management. Staff were able to describe use of information within care plans to inform care, and were aware of key risks and strategies for consumers. Validated risk assessment tools were used to identify risks for consumers and used to develop strategies in individualised care plans. Sampled wound charts had sufficient information to ensure safe delivery of wound care, with classifications and stages of the wound, measurements and photographs. Consumers with fluid restrictions were monitored for intake through monitoring cumulative intake and weekly weighing.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers 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. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | 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

Requirements (3)(b), (3)(e) and (3)(g) were found non-compliant following a Site Audit undertaken from 29 March 2022 to 31 March 2022.

**Requirements (3)(b) and (3)(e)**

Requirements (3)(b) and (3)(e) were found non-compliant because the service could not demonstrate effective management of risks and documentation associated with assessment and recording of pain and wound care, monitoring following falls and prevention of fluid overload for consumers at risk. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the pain management policy, developed a flowchart for pain assessment, and purchased validated electronic pain assessment software. Staff were provided education on pain management and process changes.
* Reviewed policies relating to falls and fall management, developed a flow chart on prevention of falls, and provided staff education on changes. The incident form has been updated to prompt pain charting and monitoring.
* Reviewed the wound management policy and engaged a wound specialist for 12 months, undertaking a wound project, provided staff education and reviewing wound data monthly.
* Electronic devices and software were purchased for timely staff documentation and improved monitoring.
* Reviewed consumers requiring fluid management, updating the nutrition and hydration assessment to include fluid balance monitoring and directives, and adding alerts to written handover processes.

The Assessment Team was satisfied these actions and improvements were effective to address the deficits previously identified in Requirement (3)(b). The service uses paper and electronic systems to effectively manage high impact or high prevalence risks associated with the care of each consumer. Consumers and representatives were satisfied with the care consumers received. Staff confirmed training undertaken, and demonstrated an understanding of processes to be followed after falls, including assessment and management of pain, and wound care. Documentation demonstrated delivery of effective care and services in line with policies, with monitoring processes to ensure safe practice is followed. Wounds were managed in line with best practices, and pain is assessed and managed to consumer and representative satisfaction.

The Assessment Team identified deficiencies in understanding of chemical restraint practice, as not all consumers administered psychotropic medication in response to changed behaviours had been identified as subject to chemical restraint. The service had not identified all consumers subject to environmental restraint in the memory support area. This was acknowledged by management during the Assessment Contact with corrective actions commenced during the visit. The provider has submitted further documentation by way of an audit, reviewed psychotropic register, and updated actions within the continuous improvement plan, demonstrating improved understanding.

In relation to Requirement (3)(e), processes ensure information about a consumer’s condition, needs and preferences is shared within the service and with others involved in the consumers’ care. Staff were aware of consumer needs and preferences. Documentation within care plans included pain documentation in line with consumer needs, and wound documentation had sufficient information to ensure safe management of wounds. The service utilises verbal and written handover processes, with written documentation updated weekly to identify consumers at risk or with changed needs.

**Requirement (3)(g)**

Requirement (3)(g) was found non-compliant due to observations of poor staff practice in the use of standard and transmission based precautions to prevent and control infection. Deficiencies in hand hygiene and use of personal protective equipment were observed. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed associated policies and procedures, additional products have been sourced and improved signage promotion is displayed for staff, consumers and representatives.
* Additional staff education has been undertaken, including introduction of new training modules on antimicrobial stewardship.

The Assessment Team was satisfied these actions and improvements were effective to address the deficits previously identified in Requirement (3)(g). Processes, policies and procedures guide staff on minimisation of infection related risk and appropriate antibiotic use. Staff could describe prevention, identification and management of infections, including obtaining pathology results to ensure the correct antibiotic is prescribed, and confirmed they received adequate training. Consumers and representatives said they were satisfied with current measures to minimise the spread of COVID-19. The service has an Infection prevention and control lead. Hand sanitiser was readily available and staff were observed using this appropriately.

For the reasons detailed above, I find Requirements (3)(b), (3)(e), and (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 29 March 2022 to 31 March 2022, where it was found the service was not monitoring and reviewing the performance of each staff member in line with policies and procedures. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Undertook an audit of overdue staff appraisals, incorporating last review date and issues identified, and used this to set new appraisal dates, with priority for those longest overdue. All overdue staff appraisals were completed by September 2022.

The Assessment Team was satisfied these actions and improvements were effective to address the previous deficits identified. The service regularly assesses the performance of each staff member, with processes in place to initiate action following feedback from consumers, other staff, audit, observations or occurrence of incidents. The service has processes for management of under performance by staff, and support is available to improve performance. Staff interviewed confirmed they had performance appraisals undertaken within the past year. Documentation demonstrated appraisals for current staff were up-to-date, with scheduled dates for the next review. Consumers and representatives stated they were happy with current staff.

For the reasons detailed above, I find Requirement (3)(e) in Standard 7 Human resources 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

Requirements (3)(c) and (3)(d) were found non-compliant following a Site Audit undertaken from 29 March 2022 to 31 March 2022.

**Requirement (3)(c)**

Deficiencies in (3)(c) related to staff not consistently following the service procedures, and management not ensuring staff practice aligned with expectations in assessment, planning and documentation of consumer care. The continuous improvement plan did not identify areas for improvement relating to deficiencies identified in audits. Workforce governance did not ensure all staff had formal evaluation of performance, and human resources policies were not followed. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided staff training on antimicrobial stewardship and open disclosure within annual mandatory training.
* Electronic devices and software were purchased for timely staff documentation and improved monitoring.
* Increased clinical oversight through regular audits, reviews of initiatives and obtaining feedback from staff education sessions.

The Assessment Team was satisfied these actions and improvements were effective to address the previous deficits identified. The service has an effective information system to ensure staff have all required information to perform their role, with hand-held devices to access and record information within each shift. The continuous improvement system captures actions from audits, clinical indicator data and logged feedback. Oversight of the workforce training and tasks is undertaken through information captured within the new software, and there is increased accountability for monitoring of staff compliance with training, police clearances and performance appraisals due. The organisation monitors for changes to legislation and regulations, and educates staff on corresponding changes, with management demonstrating effective processes applied in relation to the new Code of Conduct introduced in December 2022. Effective governance was demonstrated in relation to financial governance and feedback and complaints processes.

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant as the service was not able to demonstrate an effective risk management system and practices relating to consumer care. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Electronic devices and software were purchased for timely staff documentation and improved monitoring.
* A review of clinical policies and procedures was undertaken. Where appropriate, flow charts were introduced to guide staff.
* Education was provided to staff and evaluation undertaken before and after training to gauge staff understanding.
* Auditing was undertaken to assess the effectiveness of improvements.

The Assessment Team was satisfied these actions and improvements were effective to address the previous deficits identified. Management described improved clinical oversight through monitoring processes within the new software reporting, with analysis undertaken and reported in monthly reporting. Incident records, including Serious Incident Response Scheme, demonstrated incidents are actioned and reported in line with policies, procedures and legislative requirements. The service demonstrated improvements with pain monitoring and wound management and documentation through initiatives, including change of incident forms to prompt monitoring of pain and staff education and commencement of a wound project.

For the reasons detailed above, I find Requirements (3)(c) and (3)(d) in Standard 8 Organisational governance 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)