Performance

Report

**1800 951 822**

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| Name of service: | Villa Serena |
| Service address: | 2 Easthill Drive ROBINA QLD 4226 |
| Commission ID: | 5361 |
| Approved provider: | Allity Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 November 2022 to 9 November 2022 |
| Performance report date: | 29 November 2022 |

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 Serena (**the service**) has been prepared by E Blance, 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
* other information and intelligence held by the Commission in relation to the service.

# 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** |

**The Assessment Team did not assess all Requirements, therefore a summary or compliance rating for the Standard is not provided.**

# 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 |
| 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

**Requirement 2(3)(a)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied with the assessment and planning processes in place.

Staff could describe the assessment and planning process and communication avenues to discuss consumers’ care and service needs.

Care documentation demonstrating consideration of risks to consumers were completed in collaboration with the consumer.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the implementation of tools to track the completion and review of care documentation, completion of assessment of risks using specified assessment tools including for pain management implemented, assessment processing incorporating information from a range of sources, daily review of progress notes to identify emerging care needs, regular clinical meetings and targeted assessment audits.

The service demonstrated policies and procedures to guide staff practice were available.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 2(3)(e)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied their care and services were reviewed when their circumstances changed, or when incidents impacted their needs, goals or preferences.

Staff demonstrated an awareness of incident reporting processes and how incidents trigger a reassessment or review which was line in line with the service’s policies and procedures. Staff described meetings which were used to communicate identified changes in consumers’ health status. Staff described the use of implemented tools to track the completion and review of care documentation.

Care documentation evidenced review on a regular basis and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the implementation of tools to track the review of care documentation, review of incidents identified within progress notes, the action and monitoring of consumer’s care needs identified within hospital discharge summaries.

The service demonstrated policies and procedures to guide staff practice were available.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

# 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)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

**Requirement 3(3)(a)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied with the care they receive.

Care documentation demonstrated consumers were receiving safe and effective care including but not limited to restrictive practices, pain management and specialised nursing cares. Care documentation was current and reflected the consumer’s care needs.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the review of all consumers’ care documentation, education provided to staff for the management of pain, restrictive practices and falls prevention, daily review of progress notes, investigation of incidents, specialised nursing care audits, regular monitoring of restrictive practices as well as discussion of clinical indicators and incident management at clinical meetings.

The service demonstrated policies and procedures to guide staff practice were available.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 3(3)(b)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied with the care they receive.

Care documentation demonstrated where consumers chose to take risk, an assessment was completed in collaboration with the consumer including strategies to mitigate the risk. High impact high prevalence risks were monitored through an implemented tracker including for consumers who have a catheter, are on fluid restriction, have a pressure injury, require oxygen, are subject to restrictive practices or have a dignity of risk assessment in place. The service demonstrated the investigation and review of incidents was conducted with consideration given to root cause analysis and mitigation strategies.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the implementation of tools to monitor high impact high prevalence care needs of consumers, the investigation of all clinical incidents, regular review of progress notes, clinical risk present as an agenda item at clinical meetings, education provided to staff in relation to high impact high prevalence risks and the purchase of equipment to aid in mitigation of risks.

The service demonstrated policies and procedures to guide staff practice were available.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 3(3)(d)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied with how the service responded to their changed care needs and with the clinical care provided.

Staff interviewed had a shared understanding of policies and procedures in relation to recognising and responding to deterioration and were able to describe the identification and response to changes in consumer’s condition.

Care documentation demonstrated consumers received timely and appropriate medical review and intervention when their condition changed.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the implementation of education for staff including the recognition and response to deterioration, review of progress notes, weekly audits to identify consumers with weight loss and the weekly review of clinical indicators to monitor high risk high prevalence for consumers.

The service demonstrated policies and procedures to guide staff practice were available.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 3(3)(f)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated consumers were satisfied their referrals were timely, appropriate and occurred when needed and they had access to a doctor and/or allied health professional when required.

Staff demonstrated a shared understanding of the process for referring consumers to other health professionals. Health professionals reported timely referrals were received from the service via the medical officers and included comprehensive information.

Care documentation reflected consumers were referred to other health professionals when deterioration or a change in a consumer’s condition was identified.

Several external health professionals were observed providing care and services to consumers.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the review of progress notes, the implementation of a referral tool to ensure all staff are informed of referrals and additional referrals other than those raised on an ‘as required’ basis.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

**Requirement 7(3)(d)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated staff had completed mandatory training across a range of topics required by the Quality Standards. Staff interviewed demonstrated a shared understanding of the requirements of the Quality Standards and confirmed topics were raised and discussed at meetings. Staff were able to describe the behaviour support plans for consumers and the different types of incidents that are required to be reported under the serious incident response scheme as well as recognition of restrictive practices.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including ensuring the staff completed mandatory training topics including for restrictive practices and the serious incident response scheme, increased monitoring of completion of training through reports, scheduling of toolbox talks and discussion of the standards at meetings, the introduction of an education calendar and discussion with staff following any serious incident response scheme reportable incident.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

**Requirement 8(3)(c)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated policies and procedures were updated by the service to reflect current information including for but not limited to restrictive practices, incident management, care planning and documentation, clinical risk and corporate governance. The service demonstrated staff had access to a resource library to access policies and procedures and staff confirmed they knew how to access the library and were kept informed on changes to policies and procedures.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including the completion of transition of information to a new electronic care management system, education to staff, updates to policies and procedures including but not limited to the outbreak management plan and the implementation of a dedicated staff to monitor legislative changes and prioritise the review of the resources.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 8(3)(d)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated effective risk management system had ensured the care planning for consumers captured high impact high prevalence risks for consumers including risk mitigation strategies. Care documentation was individualised to the consumer and reflected changes were responded to in a timely manner. Documentation demonstrated staff had undergone training in topics to support the outcomes required by the Standards and staff were able to describe a shared understanding of managing risk, including for incident management as well as risk minimisation strategies.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including but not limited to providing education to staff, implementation of monitoring tools for identified risks for consumers, discussion at meetings and audits for managing risk management and systems.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

**Requirement 8(3)(e)**

This requirement was found non-compliant following a Site Audit conducted 9 February 2022 to 11 February 2022.

The service demonstrated an effective clinical governance framework through current policies and procedures and education provided to staff. Staff were able to demonstrate a shared understanding of policies and procedures.

The service demonstrated a range of quality improvements to address the previous non-compliance were undertaken including but not limited to education to staff, update of policies and procedures, the inclusion of medical officers at key governance meetings and the implementation of monitoring tools for identified risks for consumers.

It is my decision the improvements taken by the service were adequate and sustainable, and therefore I have decided this Requirement is Compliant.

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)