Performance

Report

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| Name of service: | Waterview Aged Care Facility |
| Service address: | 16 Cumberland Street TERALBA NSW 2284 |
| Commission ID: | 2391 |
| Approved provider: | Hunter Valley Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 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 Waterview Aged Care Facility (**the service**) has been prepared by Gill Jones, 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 6 September 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 4** Services and supports for daily living | **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 | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

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

Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being. This is particularly in relation to skin integrity, pain management, and restrictive practices.

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

Ensure effective risk management systems and practices, including but not limited to the following managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

# 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. | Non-compliant |

Findings

During the Site Audit conducted 2 to 8 August 2022 the service was unable to demonstrate consumers were receiving best practice care that is being tailored to their needs and is optimising their health and wellbeing. This included skin integrity, pain management, and restrictive practices. The service implemented several actions in response to the non-compliance including staff education and actions to enable consumers to move freely inside and outside the service without restrictive practices affecting their movement. The actions taken have been ineffective.

In relation to restrictive practices, Management was unable to demonstrate an understanding of restrictive practices and or restrictive practice legislation. This was previously identified in their Site Audit conducted 2 to 8 August 2022. The Assessment Team identified consumers who could not use the door fob or keypad and required staff assistance to exit the service. These consumers had not been assessed as being environmentally restrained. Management advised that all internal doors were open for free access to the outside areas however the Assessment Team found not all doors were unlocked on the ground floor for consumers to exit freely. Regarding the use of medication as a restrictive practice, discussions with Management indicated that the service had not identified potential chemical restrictive practice appropriately and that psychotropic medication, where prescribed prn, is not given as a last resort. Behaviour Support Plans lacked sufficient detail to guide staff practice in trialling other options prior to medication.

In relation to wound management, staff are not consistently attending consumer wounds according to the frequency as directed, wound photography does not clearly indicate wound healing changes, staff are not consistently using measurements to evidence the wound healing and are not consistently addressing potential wound infections or addressing consumers pain during wound care.

In relation to incident management and risk mitigation, the service has not consistently reviewed the root cause of incidents to implement further strategies to mitigate risk of reoccurrence where possible.

The Approved Provider provided a response the Assessment Team’s report on 6 September 2023. In their response the Approved Provider accepted the Assessment Team findings and proposed various actions. With regard to restrictive practices this included assessing all consumers who cannot currently exit the service without staff assistance, staff training regarding restrictive practices and increased monitoring of the use of restrictive practices. Further actions include reviewing behaviour support plans to ensure they are sufficiently detailed, are best practice and meet the legislative requirement. Actions have been taken to address issues highlighted by the Assessment Team in relation to particular consumers. The Approved Provider has addressed the issue of doors being locked by displaying the keypad number and installing a new device to ensure doors to the outside are unlocked every morning.

With regard to wound care, the Approved Provider stated they will be reviewing their wound care practices, ensured all consumers with wounds have pain charts and pain is assessed before and during wound care. Staff training has been conducted and actions taken to address issues highlighted by the Assessment Team in relation to particular consumers.

I acknowledge that the Approved Provider has undertaken a number of actions to address the issues identified by the Assessment Team, however, a number of these are not yet completed. Additionally, the changes proposed will take time to be embedded into practice.

Having considered the Assessment teams report and the response from the Approved Provider, I find Requirement 3(3)(a) Non-Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |

Findings

During the Site Audit between 2 to 8 August 2022 the service was unable to demonstrate that consumers who are unable to participate in the group activity program were supported to do things that interested them. Lifestyle assessment and planning was not always reflective of consumers’ current activity goals, needs and participation. The service implemented several actions including recruiting a diversional therapist to evaluate the current lifestyle program, as well as identify consumers who are unable to participate in group activities and develop a program that supported their interests. The actions taken in response to the noncompliance have been effective.

The service demonstrated that there were processes to ensure consumers are supported to maintain social and personal connections that are important to them. Consumer and representative feedback was positive in relation to consumers doing the things that interest them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer. Staff gave examples of how they support consumers to participate in things of interest to them and to connect with others outside the service. The lifestyle program includes internal and external community activities.

The Approved Provider did not dispute or provide a response to the Assessment Teams findings for this Requirement. Having considered the Assessment teams report I find Requirement 4(3)(c) Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

During the Site Audit between 2 to 8 August 2022 the service was unable to demonstrate staff had sufficient knowledge and skills required in relation to assessment, care planning and the delivery of care. The service implemented several actions including staff education on a range of clinical issues. The actions taken in response to the noncompliance have been effective.

The service demonstrated that there are processes to ensure the workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles. Management indicated they conduct the appropriate probity checks for prospective staff during the recruitment process. An online learning platform has been implemented which contains education modules which are assigned to staff based on their delegation. Competencies are undertaken by staff for key areas of practice. Education and competency requirements were current for the majority of staff employed at the service.

The Approved Provider did not dispute or provide a response to the Assessment Teams findings for this Requirement. Having considered the Assessment teams report I find Requirement 7(3)(c) Compliant.**Standard 8**

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| Organisational governance | |  |
| 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. | Non-compliant |

Findings

During the Site Audit between 2 to 8 August 2022 the organisation was unable to demonstrate it had adequate policies and procedures to guide staff in relation to effective risk management. The service has undertaken several actions including implementing new policies to guide staff in relation to risk management, the serious incident response scheme, supporting consumers to take risks, incident management, and restraint minimisation. The actions taken in response to the noncompliance have not been effective.

The service did not demonstrate that there were processes to ensure effective risk management and practices at organisational level. The organisation has purchased a program that contains policies and procedures, online learning/training, a care documentation program, rostering, consumer billing and other applications applicable to the business however training on the majority of policies has not occurred to embed this system. The Assessment Team identified that governance for ensuring effective risk management systems and practices was based at service level, not organisational level. At organisational level the Approved Provider is the sole person responsible. Overall, the organisation did not demonstrate effective risk management systems and practices relating to either their business risks or risks associated with managing high impact or high prevalence risks associated with the care of consumers.

The Approved Provider provided a response the Assessment Team’s report on 6 September 2023. In their response the Approved Provider acknowledged the Assessment Teams findings and stated that they are introducing new technology to assist with ensure effective risk management and governance systems but in the meantime will ensure staff are adequately trained in the systems they have currently. The Approved Provider stated that the structure of the organisation is changing. By September 2023 a Board will be in place who will be responsible for ensuring effective risk management practices are in place at an organisational level, particularly with regard to managing high prevalence, high impact risks associated with the care of consumers.

It is clear that the organisation is undergoing change and the proposed actions by the Approved Provider will take time to implement and embed into practice.

Having considered the Assessment teams report and the response from the Approved Provider, I find Requirement 8(3)(d) Non-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)