Performance

Report

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| Name: | Waterview Aged Care Facility |
| Commission ID: | 2391 |
| Address: | 16 Cumberland Street, TERALBA, New South Wales, 2284 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 22 January 2024 to 23 January 2024 |
| Performance report date: | 28 February 2024 |
| Service included in this assessment: | Provider: 853 Hunter Valley Care Pty Ltd  Service: 799 Waterview Aged Care Facility |

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 Therese Solomon, 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 (performance assessment) – 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 27 February 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Compliant |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 8** Organisational governance | **Not 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 8(3)(b)

* Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Ensure the organisation has systems and processes in place that meet all regulatory requirements, identify and minimise risks of harm to consumers and staff and ensure the provision of quality, safe care and services to all consumers.

Requirement 8(3)(c)

* Ensure effective organisation wide governance systems relation to information management, continuous improvement, workforce governance, feedback and complaints, and regulatory compliance.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices are in place, specifically related to the management of high-impact/high-prevalence risks, abuse of consumers, managing and preventing incidents.

Requirement 8(3)(e)

* Ensure an effective clinical governance framework is in place, specifically related to policies and procedures, and minimising the use of restraint.

# 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | 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 service did not demonstrate the consideration of risk to consumer’s health and well-being is being managed effectively particularly in relation to consumer behaviours. Behaviour assessment and planning did not consistently effectively assess, plan and direct consumers’ individual care and service in relation to behaviour management. The ongoing safety of consumers with changed behaviours was not effectively assessed to identify behavioural triggers or risk to their wellbeing and safety.

Review of consumers’ risk assessment and planning documentation indicated the consideration of risks to the consumers health and wellbeing was based on the consumer diagnosis and did not consistently support an individualised approach. The service did not demonstrate the ongoing assessment and planning of risk to the consumers wellbeing. The risk care plan for one consumer indicated that risk was not assessed or identified when a new significant and potentially serious risk occurred.

However, documentation in relation to restrictive practices indicated the service had generally considered the safety risks for environmental, and mechanical restraint.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(a) is found Compliant.

Requirement 2(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Review of consumer files indicate assessment and planning overall reflects consumers’ needs and preferences for all consumers sampled. However, the assessment and planning of consumer care does not identify individualised consumer goals. Documented consumer goals were clinical, and clinical staff acknowledged the goals are clinical and safety goals that are identified by the registered nurse, they are not consumer driven goals.

End of life care planning/advance care directive documentation includes what is important to individual consumers and how they want their care delivered. The clinical coordinator indicated that consumer preferences and advance care planning is discussed with consumers and/or representatives when the consumer enters the service and as needed. Some representatives indicated the service had discussed their relatives advanced care or end of life planning goals and preferences. Consumers and/or representatives indicated they were not aware of the consumer’s individual day to day goals, however, did not raise any concerned in regard to consumers’ needs and preferences.

Requirement 2(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated they have a partnership with consumers and/or representatives in the assessment and planning of consumer care. The clinical coordinator indicated the service send a copy of the care plan to the representative for their review as part of partnership in care, and stated consumers are included in the care planning process when assessments are conducted.

Documentation indicated assessment and planning included other organisations, individuals and providers of care and services that are involved in the care of the consumer. Consent is obtained from the consumer to make referrals to other health providers who provide specialist care where the service itself has been unable to meet the need or preference of the consumer. Consumers and/or representatives indicated satisfaction with the ongoing partnerships with others involved in the consumers’ care.

Requirement 2(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that the outcomes of assessment and planning are effectively communicated to the consumer and/or representative and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

The clinical coordinator indicated that outcomes of assessment and planning are communicated every three months when they send the representatives a copy of the consumer’s care plan. Consumers and/or representatives stated they had been offered a copy of their care plan, and representatives confirmed they have received a copy of the care plan every three months by email.

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has a process to regularly review the care and services they provide to consumers. The clinical staff indicated that the service reviews consumer care plans every three months and when there are changes in consumer care and condition. The care plan reviews are conducted by the registered nurse, and they are responsible for ensuring ongoing assessment when the consumers condition changes or in response to incidents. Care planning documentation indicated there is a three-monthly care plan review attended and when there has been a change in the consumers condition or consumer 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)(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)(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)(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)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | 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 did not demonstrate consistent best practice and effective oversight of consumers behaviour management, restrictive practices, and behaviour support plans. Documentation indicated there is limited interventional detail within consumers’ behaviour support plans to ensure consumers receive effective clinical care tailored to their individual behaviour. Documentation also indicated the triggers for consumers behaviours are not consistently clearly identified. Clinical staff did not demonstrate a comprehensive understanding of restrictive practices and effective behaviour management planning.

The service’s restrictive practice documentation did not demonstrate effective processes to ensure effective oversight of the consumers’ restrictive practices. The psychotropic medication awareness form did not consistently demonstrate informed consent has been obtained from the consumer and or their substitute decision maker. The service did not demonstrate they have provided the consumer/substitute decision maker with the literature regarding the medication prescribed. This forms part of the process for ensuring consumers and substitute decision makers are aware of the side effects of the prescribed medication.

The restraint form is used as part of the medical officers three monthly review and or ongoing consent process and identifies some nonpharmacological interventions to use prior to using chemical restraint. However, the form does not support that the service has reviewed the nonpharmacological interventions, as documentation indicated they were the same intervention every three months for over twelve months for some consumers.

The service did not demonstrate that when new psychotropic medications are commenced to support a consumer’s behaviour management the service has considered the medication as a chemical restraint.

The Assessment Team acknowledges in relation to wound management and pain management the service demonstrated they have processes to ensure wound care and pain management is individualised to the consumers care needs.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found Compliant.

The Assessment Team identified areas for improvement in relation to the management of high impact or high prevalence risks associated with consumer care. A lack of effective clinical governance was evident when reviewing consumers with high impact or high prevalence risks, specifically in relation to clinical oversight of care of consumer behaviours and the identification of a potential critical/serious incident for one consumer. The clinical staff and management identified consumer falls as their high impact high prevalent risk and documentation indicated the service was managing these effectively. The service however did not identify the high impact risk for consumers with changed behaviours and mental health concerns.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Compliant.

Requirement 3(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers nearing the end of their lives, documentation indicates the consumers’ care needs and preferences have been identified by staff. Their wishes and directives (advance care/end of life/care discussions) have been incorporated into the consumer’s care planning documentation and or associated documents. Documentation indicated substitute decision-maker/s are identified and documented. Consultation occurs with consumers and representatives when a consumer commences on a palliative pathway and or is nearing end stage/end of life. Clinical staff demonstrated a knowledge of palliative care processes for a consumer nearing end of life.

Requirement 3(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that consumers who have experienced a deterioration or change in their condition and physical function have their needs recognised and responded to in a timely manner. The clinical staff are responsible to liaise with the consumers medical officer when a consumer’s care deteriorates or changes, and documentation confirmed communication and consultation with the consumer and/or their representative occur. Care planning documents and/or progress notes reflect the identification of, and response to deterioration or changes in function/capacity/condition.

Requirement 3(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service communicates the consumer's condition, needs and preferences well within the organisation and with others where responsibility for care is shared. There is an electronic care program containing current consumer information including their care plans, that direct and communicate consumer care. The service has a verbal handover between shifts and outstanding matters are to be followed up by clinical staff. Consumer representatives are satisfied with the communication of consumer care, however some representative feedback indicated communication could be improved between staff working across multiple sections.

Requirement 3(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers documentation evidenced the input of others such as allied health professionals and specialists. Referrals were made when required, and there was evidence of referrals to speech pathologist, dieticians, geriatricians, dementia specialist, and wound specialist. The input from specialists and allied health professionals is generally documented in the consumers’ clinical file.

The Assessment Team identified areas for improvement in relation to consumers displaying ongoing changed behaviours, where implemented recommendations were not successful further referrals for ongoing review were not actioned in a timely manner. However, this was considered under Standard 3 Requirement (3)(a).

Overall, most consumer were referred to specialists, allied health, and other organisations in a timely manner.

Requirement 3(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Clinical staff demonstrated an understanding of antimicrobial stewardship and the principles for managing outbreaks as well as standard precautions. The service demonstrated a preparedness in relation to managing an outbreak, it has an outbreak preparedness plan and an infection prevention control lead in place.

The service has a surveillance system in place to record infection incidents. Staff record infections on an incident form which becomes part of the consumer incident register and the service clinical indicators. Staff were observed wearing face masks and practising good hand hygiene throughout the Assessment Contact. Clinical staff indicated they request the medical officer where possible to order pathology prior to commencing antibiotics.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not Compliant |
| 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. | Not 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. | Not 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. | Not Compliant |

Findings

The organisation was unable to demonstrate the governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery.

The Board and organisational governance are in their early stages. Prior to the Board being formed in September 2023 oversight was predominately at service level with service management. The Board has held one meeting in October 2023 which was the inaugural meeting, and minutes indicated that the Board developed systems and processes that will be implemented, including standing items to be included in the Board meetings agenda.

The aged care manager/Board executive provided the Assessment Team with information regarding the Board’s role and processes. However, at the time of the Assessment Contact the aged care manager/Board executive was unable to demonstrate outcomes, as the actions are planned in relation to the Board promoting and governing a culture of safe, inclusive, and quality care. These actions are not currently embedded in Board processes due to Board infancy.

The organisation’s systems and processes are still being developed including processes for governance of the service by the newly formed Board. The Assessment Team was unable to identify outcomes of processes as a result of the systems not being fully developed.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, I am of the view that the actions implemented by the approved Provider will take time to be embedded into practice and will need to be evaluated for effectiveness, therefore I find Requirement 8(3)(b) Non-compliant.

The organisation was unable to demonstrate effective organisation wide governance systems relating to information management and continuous improvement, due to the inability of the organisation to demonstrate sustainability in governance due to the infancy of the Board. The effectiveness of systems and processes was not able to be demonstrated.

The organisation did not demonstrate that there was organisational wide governance to ensure accurate and current information is communicated to stakeholders, and there is no effective governance of document control. Deficits were also identified in the governance of clinical information system related to behaviour support plans, as discussed in Standard 3 Requirement (3)(a) and Standard 2 Requirement (3)(a).

The Assessment Team identified that the organisation does not have an effective monitoring program for improvements implemented. In response to issues identified in relation to restrictive practices and behaviour management the organisation/service developed a plan for continuous improvement in relation to behaviour management and restrictive practices, however there was no effective monitoring to ensure compliance and that systems to address the deficits were fully implemented and effective.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, I am of the view that the actions implemented by the approved Provider will take time to be embedded into practice and will need to be evaluated for effectiveness, therefore I find Requirement 8(3)(c) Non-compliant.

The organisation did not demonstrate effective risk management systems and practices. The organisation was unable to demonstrate effective risk management practices at the service and oversight by the organisation. The organisation did not demonstrate that effective management of high impact risks associated with consumer behaviours occurs at a service level and is monitored through organisational governance.

The inability of the organisation to demonstrate effective risk management practices at the service and oversight by the organisation resulted in negative outcomes for consumers.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, I am of the view that the actions implemented by the approved Provider will take time to be embedded into practice and will need to be evaluated for effectiveness, therefore I find Requirement 8(3)(d) Non-compliant.

The organisation was unable to demonstrate that there were processes in place to ensure effective clinical governance. Whilst the aged care manager/Board executive has identified the need to have an organisational clinical governance registered nurse position who will also be a member of the Board, this position has not commenced and there are current deficits in clinical oversight at the service and in the organisational governance of the service.

The organisation did not demonstrate an awareness of deficits in clinical governance at the service, an effective clinical governance framework, and an understanding of restrictive practices.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, I am of the view that the actions implemented by the approved Provider will take time to be embedded into practice and will need to be evaluated for effectiveness, therefore I find Requirement 8(3)(e) Non-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)