Performance

Report

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| Name of service: | Waverley Valley Care Community |
| Service address: | 29-33 Chesterville Road GLEN WAVERLEY VIC 3150 |
| Commission ID: | 3564 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 July 2023 to 5 July 2023 |
| Performance report date: | 18 August 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 Waverley Valley Care Community (**the service**) has been prepared by S Byers, 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 25 July 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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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

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) - the approved provider ensures each consumer gets safe and effective personal care and clinical care that is best practice and in line with legislative requirements in relation to chemical and environmental restrictive practices.

# 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)(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

Consumers and representatives said they have been involved in assessment and planning and are satisfied the care and services received are safe and effective. Clinical staff explained the assessments conducted within the first 24 hours from admission, including the completion of an interim care plan. Relevant information about the consumer’s needs, preferences, and goals is gathered during the admission interview and integrated with any available pre-admission documentation. Care planning documentation recorded a range of validated risk assessment tools are completed on admission and input by a multi-disciplinary team in the assessment, planning and consideration of consumer risks.

Consumers and representatives said they are satisfied with the care and services delivered, and clinical staff contact them promptly about any incident and proposed changes to care. Consumers confirmed receiving a copy of the care plan during care consultations. Care documentation reflected communication and consultation with consumer’s and representatives in relation to assessment and planning outcomes and care plan updates. Staff said they provide a copy of the care plan to the consumer and representative during the care conference, upon request. If the representatives are unable to attend the service, clinical staff schedule a phone conference to provide care and services updates, and a copy of the care plan is sent via email.

Consumers and representatives were satisfied that staff regularly communicate with them when circumstances change or incidents impact on the needs, goals and preferences of the consumer. Consumer care documentation reflected care plans are reviewed 3-monthly or more frequently when changes or incidents occur. Clinical staff undertaking reviews described the review process and demonstrated understanding when a review or reassessment may be required. Management described how they review progress notes to ensure any change the consumers health status is reflected in care plans. The service demonstrated it has a care planning policy in place to support staff practice in conducting timely and appropriate consumer assessments within the established timeframes.

Based on the evidence available, I find Requirements 2(3)(a), 2(3)(d) and 2(3)(e) are 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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 3(3)(a) is Non-compliant:

Of the six consumers sampled, the Assessment Team identified four consumers to be potentially subject to chemical restraint. The four consumers had been administered psychotropic medication with the reason to influence behaviour without appropriate assessment and evidence of valid informed consent for the use a restrictive practice. In response to feedback, the service obtained evidence of informed consent for the use of chemical restraint for two consumers. Medications for the two other consumers were reviewed by the general practitioner and ceased in consultation with the consumer and their representative.

The Assessment Team also identified four consumers residing in the service’s secure Memory Support Neighbourhood (MSN), who while ambulant, were not able to leave the MSN independently or unaccompanied by staff. Consumer files did not evidence informed consent related to the environmental restrictions of the MSN consistent with legislative requirements. Management said they do not consider consumers who reside in the service’s MSN who are not actively ‘exit seeking’ to be subject to environmental restraint. During the assessment contact, the Assessment Team were approached by two consumers seeking to leave the MSN. Staff were observed to re-direct the consumers, not allowing them to leave. In response to feedback, the service obtained evidence of informed consent for the use of environmental restraint for the two consumers.

The Approved Provider disagrees with the findings of the Assessment Team. The Approved Provider submitted a written response with clarifying information and supporting documentation including lifestyle review, progress notes, clinical reports, flowcharts, restrictive practices policies and education material.

In relation to chemical restrictive practice, the Approved Provider does not consider the consumers identified by the Assessment Team to be subject to chemical restraint. However, the Assessment Team identified that medication had been administered for the intent of managing behaviours which is considered chemical restraint. The Approved Provider’s response did not recognise that medication used to treat a medical condition or mental illness, however, can also be used as a chemical restraint it has also been prescribed with the intention of managing behaviour. While staff may have incorrectly documented the reason the medication was administered on occasions, the service has not demonstrated appropriate assessment, how the provider is satisfied the rationale for use is clearly documented or recognised this medication use may be considered chemical restraint.

In relation to environmental restrictive practice, the Approved Provider’s response supports the position of service management, confirming they do not consider that consumer’s residing in the MSN to be subject to environmental restraint as they do not seek to exit. Rather than to manage behaviours, the Approved Provider asserts that consumers in the MSN are provided an environment that supports dementia design principles and receive care from staff with relevant dementia care training. While there is evidence to support that consumers are free to move within the defined MSN environment, consumers are not able to leave the MSN unaccompanied or move freely throughout the service, which has the effect of restricting their free movement and can be considered environmental restraint. For consumers residing in the MSN, the Approved Provider’s response did not demonstrate consistent and correct understanding and recognition of practices or interventions that are restrictive practices in accordance with the Quality of Care Principlesdefinitions. This includes appropriate assessment to determine when the intervention (secure environment) is or is not a restrictive practice (environmental restraint).

The Approved Provider submitted a Plan for Continuous Improvement demonstrating the actions planned and completed to address the deficits. Actions include review of current practices, education in restrictive practices and documentation, monitoring by clinical management and review of communication processes with general practitioners..

I acknowledge the work the service has undertaken to date, including a full review of all consumers potentially subject to chemical and environment restraint at the service, however, the outcome of the review found that no further consumers were subject to chemical or environment restraint. While the Approved Provider considers the Assessment Team’s findings do not indicate a systemic issue, management’s understanding at the time of the assessment contact, and the Approved Provider’s response demonstrates a lack of appropriate assessment and recognition of environmental and chemical restraint in accordance with the Quality of Care Principles definitions which appears to apply to a broader cohort of consumers, particularly those within the secure Memory Support Neighbourhoods.

I am satisfied the Approved Provider demonstrated safe and effective care is delivered in relation to management of pain, skin integrity and wounds, falls and weight loss.

In making my decision I have considered the assessment team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the assessment contact, these actions have not been fully implemented, evaluated, and embedded. I am not satisfied the Approved Provider has demonstrated it has effective systems in place to ensure understanding of chemical and environmental restrictive practices is used in line with best practice and legislative requirements. I find Requirement 3(3)(a) is Non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |

Findings

Consumers and representatives described the services and supports available to promote emotional and psychological well-being, including access to church services, pastoral services, volunteers and one-to-one time with staff. Staff demonstrated knowledge of individual consumers’ emotional, spiritual, and psychological needs and how they support consumers through the services one-to-one program. The service demonstrated it holds three religious services monthly and a priest visits consumers weekly. Care planning documents aligned with information provided by consumers and staff.

Based on the evidence available, I find Requirement 4(3)(b) is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Consumers and representatives were satisfied that appropriate and timely actions were taken in response to complaints. Consumer’s provided examples where management were responsive to and resolved complaints to their satisfaction including the application of open disclosure principles in practice. Staff demonstrated understanding of the service’s complaints and open disclosure processes. Management described how they review feedback daily and speak directly with consumers and representatives to resolve complaints. Complaints documentation reflected complaints are investigated, actions completed and closed off in a timely manner.

Based on the evidence available, I find Requirement 6(3)(c) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Consumers and representatives were satisfied with the level of staffing, call bell response times and the quality of care delivered. Some consumers and representatives provided feedback that agency staff were less familiar with the needs of consumers. Staff said the level of staffing has improved and unfilled shifts are filled with permanent staff working extra hours or with agency staff from one agency to support continuity of care. Management described how the workforce is planned to ensure the correct skill mix and number of staff including 24/7 registered nurse coverage enables the delivery of safe and effective quality care and services. Call bell reports demonstrated that call bells are responded to in a timely manner. Management explained they regularly audit and monitor call bell response times to improve service delivery. Roster documentation demonstrated all shifts were filled by permanent and agency staff for the fortnight prior to the assessment contact.

The service demonstrated it has formal and informal processes in place to monitor and review the performance of each member of the workforce. Processes include an induction program for new employees, day-to-day work performance monitoring, and formal documented performance appraisals. Review of staff performance is conducted within 3 months of recruitment, at 6 months, and all staff are scheduled for and participate in ongoing annual performance appraisals. All staff interviewed confirmed participating in an annual performance appraisal and this was supported by staff documentation. The service has policies and procedures to guide management and staff in performance management and disciplinary procedures.

Based on the evidence available, I find Requirement 7(3)(a) and 7(3)(e) are 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)