Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Wellington Park Private Care |
| Commission ID: | 5362 |
| Address: | 16 Balmoral Street, WELLINGTON POINT, Queensland, 4160 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 8 May 2024 to 9 May 2024 |
| Performance report date: | 11 June 2024 |
| Service included in this assessment: | Provider: 1659 Superior Care Group Pty Ltd  Service: 3707 Wellington Park Private Care |

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 Wellington Park Private Care (**the service**) has been prepared by Bruce Bassett, 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 24 April 2024 which acknowledged and accepted the recommendations of the Assessment Team report.

# Assessment summary

|  |  |
| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Not Applicable |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **Not Applicable** |
| **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.

* The service needs to ensure that high impact, high prevalence risks to consumers are consistently documented in initial assessments and care plans. The service also needs to ensure regular reviews of consumer care and service plans are completed as per the service’s assessment and planning policy.
* The service needs to ensure that its information systems are effectively understood and utilised by staff to ensure appropriate care planning documentation for consumers are created and maintained.
* The service is required to ensure that it meets all its regulatory obligations, particularly in relation to the management of restrictive practices and reporting.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | |  |
| 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 |

Findings

Requirement 2(3)(d)

Consumers said staff discuss their care needs with them and provide a copy of their care plan if they wish for one. Staff advised they have access to care plans for consumers they are providing care for through the electronic care management system (ECMS), summary care plans located in consumers’ rooms and handover records. Consumer care documentation demonstrates the outcomes of assessment and planning are mostly documented in a service and care plan. The Assessment Team observed care planning documents and handover records are readily available to staff delivering care.

Consumers and their representatives confirmed staff discuss consumers’ individualised goals with them around issues such as recovery from wounds, maintaining their mobility and care preferences. Consumers confirmed their care plans are reviewed with their input on a regular basis. However, consumers who were new to the service did not have their 24-hour admission plan of care and following 28-day assessment and planning of care consistently documented in a plan of care as per the service’s admission assessment and planning of care policy.

Registered staff and care staff advised consumer handover is completed at the beginning of each shift and informs them of changes to consumers’ care needs. The ECMS has a handover page updated with changes in consumers’ care needs. Registered staff advised they discuss changes in consumers care needs with them.

Care documentation demonstrated consumers’ goals, preferences and care needs are documented in a plan of care. For example, review of files for consumers with wounds or pressure injuries (PI), diabetes, or who were at high risk of falls, all had documented treatments plans and management strategies documented. Care documentation reviewed demonstrated visiting health professionals’ recommendations for care was included in the consumer’s plan of care.

Whilst admission assessment and planning of care is not always documented in the consumers’ care plan, overall, the service has systems in place to ensure consumers’ care and service needs are communicated to those providing care. Therefore, I have decided that Requirement 2(3)(d) is Compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Not 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 |

Findings

Requirement 3(3)(a)

This requirement was found not compliant following an unannounced assessment contact on 6 February 2024. The deficiencies identified related to time sensitive medication administration, and management of diabetes, falls management and restrictive practices. The service has taken actions to address these issues. The service has also implemented systems to ensure the actions taken are monitored and are sustainable.

Consumers who require time sensitive medication advised the Assessment Team the medications were provided on time every day as per their Medical Officer (MO) directions. Staff said, and care documentation confirmed, there are medication care plans in place which provide guidance on the medication administration regimen. Additionally, staff described escalation procedures to follow if a time sensitive medication is missed, including reporting anomalies to the MO.

Review of documentation for consumers with a diagnosis of diabetes demonstrated completed diabetes management plans. Documentation supported that diabetes and Blood Glucose Level (BGL) monitoring are managed as prescribed in diabetes management plans, and individualised strategies are implemented to minimise risk to consumers sampled.

The service has implemented monitoring systems to ensure consumers with a diabetes diagnosis are identified and diabetes management plans are completed. For example:

* + The current Plan for Continuous Improvement (PCI) identifies all consumers with a diagnosis of diabetes had a diabetes management plan completed.
  + The service risk register includes a reminder that consumers with a diagnosis of diabetes are to have completed diabetes management plans and this is to be monitored by clinical management.

Review of documentation for consumers who had recent falls demonstrated staff monitored the consumers for deterioration post falling for 3 days, assessed them for changes in care needs and injury post fall, and referred consumers to appropriate health professionals for review if required.

Registered staff interviewed could describe post falls management strategies for consumers and advised they have received training on falls management strategies, while clinical management staff advised they review consumer incidents and progress notes daily and follow up with staff if post falls management is not completed as per the service’s falls management policy.

With respect to restrictive practices, review of consumer care documentation and the restrictive practice register demonstrated consumers identified as being subject to a chemical or environmental restraint have an individualised behaviour support plan (BSP), appropriate health professional authorisation and representative consent.

The service demonstrated effective monitoring systems to ensure consumers identified as being subject to restraint have a BSP, representative consent and appropriate health professional authorisation. Care and registered staff were able describe individualised consumers’ BSP to manage consumers’ changes in behaviours.

The Assessment Team identified two consumers with a diagnosis of dementia and anxiety who were prescribed as required psychotropic medication to manage aggression, which had not been considered a chemical restraint. However, review of the consumers’ documentation identified the psychotropic medication had not been administered in the last three months for management of behaviours.

Management advised they would review the psychotropic register to identify any other consumers with a diagnosis of dementia and prescribed medication to manage agitation. If the psychotropic medication is prescribed for agitation in relation to a diagnosis of dementia, they would identify the medication is a chemical restraint and they would discuss with the MO and appropriate consent would be obtained.

Overall, consumers and representatives interviewed said they were satisfied with personal and clinical care being provided at the service and that care and services meet the consumers’ individual needs. Care documentation demonstrated effective care was provided for consumers in relation to management of wounds, personal hygiene and continence. Staff interviewed confirmed consumers are receiving individualised care which is safe and right for the consumer and based on best practice.

Consumers interviewed said staff ensure their wounds are treated and staff discuss with them how the wound is healing or deteriorating. Management provided a wound report that demonstrated consumers are receiving wound treatment as planned. Care documentation supported wound management as prescribed in wound and skin integrity management and evaluation plans.

Clinical management review the wound care report daily to ensure that wound care is managed effectively. Management advised they follow up with individual staff members if wound management has not been completed and wound care is a standing agenda item at clinical meetings for ongoing discussion of effective wound care management.

Review of the service’s current PCI demonstrated ongoing monitoring of wound care actions and recorded an identified improvement of recording of wound care.

Consumers and representatives interviewed said consumers receive their personal care preferences including time of day, shower or sponge bathing and carer gender. All consumers and representatives interviewed said, and observations by the Assessment Team confirmed consumers are well groomed and all their personal hygiene and continence needs are met**.**

There are personal hygiene and continence care plans in place which provide guidance on consumers’ preferences and needs. Additionally, functional assessments are completed for assistive devices such as personal slings and incontinence aid assessments are completed and documented.

As the service has implemented actions and systems to correct the previously identified deficiencies and was able to demonstrate consumers are receiving quality care and services that meet their individual needs, I have therefore decided that Requirement 3(3)(a) is now Compliant.

Requirement 3(3)(b)

The service acknowledged during the assessment contact that high impact, high prevalence risks to consumers exist as the service is not consistently documenting consumers’ admission assessment and planning of care and services in a care and service plan. The service also self-identified regular reviews of consumers’ care and service plan were not completed as per the service’s assessment and planning policy. Whilst the service has taken actions to address this deficit staff did not have a shared understanding of the actions taken.

The Assessment Team identified eight consumers who had entered the service over a recent one-month period did not have an initial 24-hour assessment and planning of care needs documented and six consumers over a similar period did not have a 28-day care plan completed. Review of consumers’ care plans identified consumers’ care needs were not consistently documented.

Registered staff expressed uncertainty on whether the registered staff or clinical management completed consumers’ admission assessments and planning of care and the senior clinical team did not have a shared understanding of how the ECMS generates a report on completed admission care plans.

Documentation provided by management demonstrated 60 of the 90 consumers at the service have care plans which are overdue for review, contrary to the service’s policy of 3 monthly review of all care plans.

In response to feedback provided by the Assessment Team, management advised the service had recently engaged a clinical review nurse to manage care plan reviews and management provided evidence of an overdue care plan review schedule for completion by allocated registered staff. The clinical review nurse will provide monitoring and review information of the planned and improved care planning process at weekly clinical governance meetings and inform management of progress made by registered staff, including identification of non-compliance with the schedule.

Management advised there is a planned completion date of 30 June 2024 for all care plans to be brought up to date with immediate and ongoing oversight to be provided by the new clinical review nurse.

I have decided Requirement 3(3)(b) is not compliant as staff are currently unfamiliar with the service’s care planning processes, care plans for the majority of consumers at the service are overdue for review and the service’s system to ensure completion of admission care plans and care plan reviews has not been fully implemented and evaluated by the service for sustainability.

Requirement 3(3)(d)

The service was able to demonstrate changes in consumers’ health and well-being are recognised and responded to in a timely manner. Care staff said they report any changes or deterioration in consumers’ condition to registered staff or clinical management. Registered staff explained the assessment process following changes to a consumer’s condition. Care documentation reflected the identification of, and response to, deterioration or changes in the condition of consumers.

Staff have access to clinical information to guide practice in recognising and responding to deterioration or changes in consumers’ condition and the service has clinical staff on duty 24 hours a day, 7 days a week, with registered staff allocated to each of the 2 service wings during the day. Staff were able to describe signs related to deterioration including changes in mobility, appetite and behaviour, and clinical observations. Care staff demonstrated a shared understanding of their responsibility and the process to escalate observed changes in consumers to the registered staff.

Clinical management advised they review consumers’ pre and post hospital admission to identify care provision has been appropriate and delivered in a timely manner; and they follow up with staff at handover and staff individually when improvements to care are identified. Clinical management also advised they report to the centre manager and heads of departments daily on staff management of consumers’ deterioration.

Following consideration of the above information, I have decided that Requirement 3(3)(d) is Compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a)

The service was able to demonstrate the workforce is planned to enable the delivery of safe and quality care and services. Consumers and their representatives considered there are enough staff at the service to meet consumers’ needs. Management has contingency plans in place to replace staff when required and rosters are reviewed on a regular basis to ensure staff allocations are adequately meeting changing consumer needs and preferences.

The service uses a base roster for permanent staff with casual staff and permanent staff to fill a vacant shift where possible before utilising agency staff. When the service experiences unplanned leave, the service will invite permanent and casual staff to fill vacant shifts using an electronic messaging system. If any shifts remain vacant, agency staff are used where possible. A review of the service’s previous 4-week roster log identified minimal unfilled shifts. The roster is reviewed regularly by management to assess if the number and mix of staff members rostered is adequate to meet the changing consumer needs and preferences.

Consumers said staff are available to them when needed and attend quickly in response to call bells. Staff said there are adequate staff to provide care and services in accordance with consumers’ needs and preferences and they generally have enough time to undertake their allocated tasks and responsibilities.

Following consideration of the above information, I have decided that Requirement 7(3)(a) is Compliant.

Requirement 7(3)(d)

Consumers and representatives expressed confidence in the ability of staff to deliver care and services, and said they believe staff are well trained and equipped to perform their roles.

Care staff and management were able to describe the process of recruiting and training staff and consumers provided positive feedback on the staff who deliver care.

Staff described the orientation and onboarding process which includes mandatory training, competency assessments, role specific training, training on the Quality Standards and buddy shifts with more experienced staff. Staff also confirmed the service provides ongoing professional development and supervision and management support staff who request further training and education. Staff confirmed the service supervision and support they receive from management and other staff on commencement at the service.

Management advised they have a monitoring process in place for ensuring staff are compliant with completion of mandatory training. Training records are reviewed at least weekly by the training co-ordinator, with emails sent to staff for upcoming due dates. When staff have not completed their required training by the due date they are followed up by the management and if further non-compliance is evident, they are removed from the roster until all training is completed.

Following consideration of the above information, I have decided that Requirement 7(3)(d) is Compliant.

Requirement 7(3)(e)

The service was able to demonstrate systems are in place to assess, monitor and review staff performance. Staff confirmed how they are engaged in their professional development including opportunities to request specific training relevant to their role.

Staff confirmed the service has probationary and ongoing performance review systems in place, with staff indicating they have been involved in a performance appraisal since commencing with the service and advising they have had a performance appraisal in the last 12 months.

Performance appraisals involve discussions of staff performance and areas in which the staff member requires development. Thereafter, staff are required to undertake bi-annual performance appraisals which involve staff engaging in self-reflection, answering questions relating to their overall satisfaction in their role and identifying education needs to further their skills and knowledge.

Staff performance is monitored through observations, analysis of clinical data, and consumer and representative feedback. Any issues in performance identified through these monitoring mechanisms are addressed immediately by both the service and organisation’s education and management teams.

A review of the performance review and orientation register confirmed all staff had engaged in a performance review within the last 24 months.

While there were inconsistencies in the service’s policies relating to performance reviews and the frequency in which performance reviews were conducted, management was receptive to the Assessment Teams feedback and committed to reviewing the policies and ensuring they were reflective of the organisations expectation of performance reviews.

The organisation has a suite of documented policies and procedures that guide the selection and recruitment of new staff, orientation, and probationary processes, monitoring of staff performance, and performance management.

Following consideration of the above information, I have decided that Requirement 7(3)(e) is Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | 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. | Compliant |

Findings

Requirement 8(3)(c)

The service was previously found to be not compliant in this requirement following an unannounced assessment contact on 6 February 2024. The deficiencies identified related to ineffective reporting capabilities in the service’s ECMS and poor information management systems, low levels of compliance with mandatory training within the workforce and a failure to comply with regulatory reporting requirements.

The Assessment Team report indicated that the service was not consistently ensuring effective governance systems in relation to information management and regulatory compliance.

Information Management

While previous deficiencies identified regarding the documentation of medication administration, diabetes and wound management appear to have been addressed by the service, senior clinical staff continue to lack a shared understanding of the reporting capabilities of the ECMS in relation to providing reports on outstanding consumers’ admission care and service plans. This has resulted in the service failing to identify that initial and first month assessments for consumers entering the service have not been completed.

Staff were not accessing updated policy and procedures on the service’s intranet. For example, management was able to demonstrate all staff had been advised of how to access the intranet however reports generated from the intranet identified more than fifty percent of staff had not accessed the intranet. Staff interviewed did not have a shared understanding of how to access policies and procedures on the intranet. This included senior clinical staff tasked with monitoring that the service’s policies and procedures were followed in relation to consumers’ care and service needs.

In response to the Assessment Team’s feedback during the assessment contact, management advised additional training and information will be provided to staff regarding how to access the intranet to locate policies and procedures, and the issue will be added to the agenda of all staff meetings until staff usage of the information system has been improved and evaluated.

Continuous Improvement

The Assessment Team confirmed through interviews with management and review of documentation that the service has effective systems and processes in place to support continuous improvement.

Opportunities for improvement are identified through a range of sources including but not limited to consumer and representative feedback, audit and survey results, clinical indicator trends and critical incident data.

The service’s PCI and monthly quality meeting minutes were reviewed and confirmed the service tracks and manages planned and completed improvement actions in relation to various areas of care and service delivery.

Financial Governance

The service has a budget allocation that is designed to meet the financial needs of the service and ensure the delivery of quality care and services.

Staff, such as care and clinical staff, lifestyle staff and support staff reported that they had access to sufficient materials and equipment to perform their roles.

Sampled consumers said goods and equipment met their care and service needs.

Workforce Governance

The service has job descriptions and duty lists for staff that enable them to meet consumer’s care and service needs.

The service has a trained infection prevention and control lead (IPC), and the current PCI demonstrates the service is supporting other registered staff to enrol in the IPC training. The lack of an IPC was previously identified as a deficiency.

As discussed under Requirement 7(3)(d), the service has also addressed the previously identified deficiency regarding poor completion of mandatory training by staff. The Assessment Team report confirmed that most staff are up to date with their mandatory training requirements and the service has monitoring procedures to bring the remaining staff into compliance.

Regulatory Compliance

While the service has remedied previously identified non-compliance with regulatory reporting requirements, the Assessment Team report indicated that consumers were not able to move freely outside of the service due to pin code operated doors. Consumers who were not intended to be subject to an environmental restraint did not have strategies in place to support them to independently move freely.

In response to this feedback, management undertook to complete risk assessments to ensure consumers are safe and able to leave the service independently if they wish to.

Feedback and Complaints

The service demonstrated an effective feedback and complaints system. Consumers, representatives and staff said they know how to make complaints and provide feedback and expressed confidence management would take appropriate actions in response. Management described processes for review of consumer and representative feedback and provided examples of using feedback to improve the quality of care in the service.

As a result of ongoing deficiencies identified by the Assessment Team with respect to information management and regulatory compliance systems in the service, I have decided that Requirement 8(3)(c) remains Not Compliant.

Requirement 8(3)(d)

The service was able to demonstrate effective risk management systems and practices.

The service has an incident management system and incidents are reviewed daily by senior clinical staff to ensure incidents are managed. Review of the service’s incident management system demonstrates incidents are managed in a timely manner.

The service has a consumer risk register that is managed by senior clinical staff to monitor the effectiveness of care and services provided. For example, senior clinical staff said they recently identified from reviewing the risk register that a backup stock of pressure relieving mattresses was needed for timely application when a consumer’s care needs change. The service has purchased pressure relieving mattresses to be kept in stock and staff confirmed they can apply the mattresses in a timely manner.

Senior staff attend daily heads of department meetings and risks to consumers care and service needs are discussed, and actions taken when risk is identified. Senior clinical staff attend daily handover and read consumers’ progress notes to identify risk. Review of staff and board meeting minutes identified risk is monitored and actioned.

The service’s PCI identifies training in relation to clinical deterioration was provided to staff in April 2024 following identification of this as a potential risk. Assessment and care planning processes identify high impact and high prevalence risks to consumers such as falls, going on outings, eating difficulties and outbreaks of infectious disease.

The service has an incident management system and incidents are reviewed daily by senior clinical staff to ensure incidents are managed. Review of the service’s incident management system demonstrated incidents are managed in a timely manner.

Following consideration of the above information, I have decided that Requirement 8(3)(d) 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)