Performance

Report

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| Name of service: | Westminster Village Nursing Home |
| Service address: | Cnr Fort Street & Sylvan Way GRANGE SA 5022 |
| Commission ID: | 6941 |
| Approved provider: | UnitingSA Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 9 March 2023 |
| Performance report date: | 14 April 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 Westminster Village Nursing Home (**the service**) has been prepared by K Richards, 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 consumers, representatives, staff, management and others;
* the provider’s response to the Assessment Team’s report received 04 April 2023; and
* the Performance Report dated 14 October 2022 in relation to the Site Audit conducted from 16 August 2022 to 18 August 2022.

# 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 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **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** |

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

# 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)(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 |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022, where it was found the service had not discussed end of life wishes and preferences with consumers resulting in care planning documentation not including advance care planning and end of life care wishes The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Undertaking a site audit of status of captured advance care directives (ACDs) for monitoring and ongoing follow up.
* Incorporating collection of ACDs within admission processes.
* Educating consumers on the importance of ACDs and end of life planning during a Resident Meeting.

However, the Assessment Team were not satisfied assessment and planning captured consumer needs, goals, and preferences for end of life. The Assessment Team reported management could not identify how many consumers did not have an ACD, electronic care plans did not include palliative care plans, care staff could not identify where to obtain information about end of life care needs and preferences, and two sampled care files for consumers receiving end of life care did not demonstrate information was updated.

The provider has refuted the Assessment Team’s report, including the information relevant to my findings:

* Advance care planning is included as part of the admission care planning process, along with capturing end of life goals or preferences if the consumer wishes.
  + A copy of the Admission Form, Admission Tick Sheet, and Care Plan Management Procedure were provided, demonstrating process to capture ACD and palliative care details upon admission.
  + The Care Plan Management Procedure states review is required when care needs change or on a six monthly basis.
* When consumers are identified as nearing end of life, a comprehensive End of Life Care Pathway (EoLCP), triggering review of medical interventions, advance care planning, spiritual/religious/cultural needs, comfort planning, and communication with consumer representatives.
  + A completed copy of an EoLCP for one of the named consumers was included within the response, demonstrating assessment, consultation with family, and assessment of needs. Dates on the form were prior to the Assessment Contact. It is noted the other named consumer was identified as nearing end of life the day before the Assessment Contact.
* A copy of the ACDs and palliative care plans for named consumers within the report. Dates on these documents pre-date the Assessment Contact.
  + The ACD includes values and wishes where identified, or state ‘No Directives Provided’, and is signed by a witness.
* Care plans include Vital Information Details, identifying presence of ACDs for quick reference by staff.
* All care staff have access to care planning through the electronic care management system and should be able to identify relevant information on consumer needs and preferences, including for end of life.
  + I further note evidence provided in Standard 3 Requirement (3)(c), indicating staff were aware of care provided in consultation with consumers, and updates or changes were communicated through verbal handover processes.
* The Assessment Team referred to an absence of personalised consumer information within the Palliative Care folder, however, this is used to store resources to guide staff, copies of blank assessment forms, planning processes, and referral forms for external palliative care services, and was not intended to contain personal information.

The provider notes whilst all efforts are made to prompt consideration of advance care and end of life planning from admission or guided tours, there is no legal requirement for a consumer to have an ACD. The service uses reporting as a register to identify consumers who have ACDs for monitoring, and consumers are regularly consulted as part of care planning. The provider states whilst they have addressed the previous non-compliance, they are always looking for continuous improvement, and have provided a plan with further activities they intend to undertake, including ensuring all clinical staff can undertake an ELDAC After Death Audit, seeking to appoint a palliative care champion, and a request was sent to lifestyle staff seeking interest in attending daily meetings to discuss key consumer needs, including end of life care and deaths of consumers.

I find evidence demonstrates the service has a system and process to provide supportive opportunities for consumers to discuss dying and make their wishes known. Documentation submitted by the provider demonstrates the service undertakes assessment and planning to capture needs, goals, and preferences. This includes advance care and end of life planning, noting that not all consumers wish to consider their needs or preferences in advance. Consumers had ongoing consultation to monitor for changing needs, and consumers entering end of life care had comprehensive review undertaking, including consulting with the consumer and/or representatives, within the EoLCP documentation. In coming to my decision, I have also relied on the Assessment Team’s findings within Standard 3 Requirement (3)(c), confirming needs, goals, and preferences of consumers nearing end of life are recognised and addressed.

For the reasons detailed above, I find Requirement (3)(b) in Ongoing assessment and planning 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)(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 |

Findings

Requirements (3)(a) and (3)(c) were found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022.

Requirement (3)(a) was found non-compliant because the service could not identify all consumers subject to chemical restraint and not all consumers subject to restrictive practices had available consent for use or behaviour support plans. Furthermore, staff were not identifying consumer wounds or following the wound management policy. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Updating of the restraint register to ensure it correctly identifies consumers and type of authorised restraint. Ongoing audits are undertaken by the Clinical Nurse.
* Reviewing the organisational procedures for minimising use of restrictive practices to ensure alternate strategies are available, utilised, and documented in progress notes.
* Increasing the monitoring of wound care through frequent and ongoing audits.

The Assessment Team were satisfied these actions and improvements were effective. Consumers with environmental or chemical restraint had necessary authorisations and risk assessments and behaviour support plans. Documentation demonstrated chemical restraint use was minimised, and when required, alternate behaviour management strategies had been trialled. Changes to wound care, including weekly audits with monthly reporting, has resulted in increased insight from senior clinical staff or wound specialists, and documentation demonstrates improvements to wound healing. Staff receive education about pain assessment process, and consumers said they were happy with care and do not have pain.

Requirement (3)(c) was found non-compliant because consumers nearing end of life did not have effective monitoring and management of pain, and care planning documentation did not include end-of-life information or preferences to guide staff practice. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provision of staff education on palliative care.
* Introduced a Palliative Care folder with resources to guide staff and copies of documentation forms, including assessment and monitoring tools and referrals for external palliative care services.

The Assessment Team were satisfied these actions and improvements were effective. Consumers receiving end of life care received regular assessment of needs, with changes communicated to staff through handover processes. Staff could explain how they provided care to maximise consumer comfort and preserve dignity. Documentation showed consumers receiving end of life care were reviewed at least every two hours with charted observations of pain, personal care, and family attendance recorded in end of life charting. Use of pain relief was recorded and evaluated for effectiveness.

For the reasons detailed above, I find Requirements (3)(a) and (3)(c) in Standard 3 Personal and clinical care Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement (3)(f) was found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022, where it was found consumers considered meals were tasteless, repetitive, often served cold, and not of good quality. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Establishing a food focus group, meeting bi-monthly to capture consumer feedback and suggestions on meals, catering services, and the dining experience.
* Appointment of a new Chef, who will work with consumers providing complaints on food to resolve concerns.
* Introduction of vegetarian and vegan meal options, and monthly culturally themed meals.
* Installing electronic display monitors in dining areas to display daily menu choices.

The Assessment Team were satisfied these actions and improvements were effective. Consumers and representatives said they were happy with meals provided, describing favourite meals. Staff advised consumers are asked meal preferences daily for the next day, but are supported to change their mind and be provided alternate meals. Feedback registers demonstrated consumers unhappy with food were followed up by the Hotel services manager and Chef with appropriate steps taken to resolve concerns.

For the reasons detailed above, I find Requirement (3)(f) in Standard 4 Services and supports for daily living Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022, where it was found consumers residing in the memory support unit were unable to move freely between internal and external areas of the unit, and risks relating to a build up of consumer laundry on weekends. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Directives issued to staff to ensure the memory support unit doors to external areas were unlocked in the morning and secured only in the evenings. Daily monitoring of compliance with the directive is undertaken by senior staff.
* Additional hours have been rostered for weekend laundry staff to prevent a build-up of personal laundry for consumers.

The Assessment Team were satisfied these actions and improvements were effective. The doors in the memory support unit were observed to be unlocked, and staff confirmed the directives were followed. Consumers and representatives said the service is clean and well maintained. Rosters confirmed ongoing scheduled laundry hours, and feedback evaluation confirmed consumers and staff were satisfied with changes. Staff were aware of processes to log maintenance issues and records demonstrated use of preventative and reactive maintenance activities are undertaken in a timely manner. Cleaning staff were directed by available schedules and described additional cleaning duties due to COVID-19 outbreaks. Consumers were observed moving freely within internal and external areas of the service.

For the reasons detailed above, I find Requirement (3)(b) in Standard 5 Organisation’s service environment 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 |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022, where it was found there was insufficient staffing to complete all required care and service tasks, resulting in representatives assisting with personal care, and delays in laundry services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* The staffing model was reviewed, including staff feedback of workloads and consumer needs analysis, to align staffing ratios to meet consumers’ current care and service needs. This resulted in additional shifts for care and laundry staff.

The Assessment Team were satisfied these actions and improvements were effective. Consumers and representatives confirmed there are adequate numbers of suitably skilled staff, and they do not experience delays in care and service provision. Staff confirmed involvement in the process to review the staffing model, felt listened to, and have adequate time to provide care and services for consumers. Management detailed processes to ensure the workforce is planned, and skill mix considered in allocations, with recruitment of additional staff to reduce use of agency staff and improve quality of care through consistency of staffing. Roster allocation sheets demonstrated planned and unplanned leave was covered to ensure adequate workforce for care delivery.

For the reasons detailed above, I find Requirement (3)(a) in Human resources Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 16 August 2022 to 18 August 2022, where it was found consumers transferring from another closing service had not been engaged in the admission process.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* The Residential operations manager met with consumers dissatisfied with the admission process to capture complaints, and implement resolutions. Complaints and responsive actions were captured within the feedback log.

The Assessment Team were satisfied these actions and improvements were effective. Consumer and representative interviews corroborated they can take part in improving care and services and receive information through a variety of ways. Consumers are engaged and supported in the development, delivery and evaluation of care and services through various feedback mechanisms such resident meetings, food focus groups, lifestyle questionnaires and the care plan review process. Improvements within the service are communicated to consumers via resident meetings. The monthly newsletter includes a ‘message from the manager’ section who advises of future events and the details of any improvements being made to the service. Food focus group minutes include discussion points, actions, and progress, and was attended by 32 consumers.

For the reasons detailed above, I find Requirement (3)(a) in Standard 8 Organisational governance 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)