Performance

Report

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| Name of service: | William Beech Gardens - Bushmaster |
| Service address: | 1 Madline Street Condobolin NSW 2877 |
| Commission ID: | 2648 |
| Approved provider: | RSL LifeCare Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 27 June 2023 |
| Performance report date: | 9 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 William Beech Gardens - Bushmaster (**the service**) has been prepared by Melissa Buhagiar, 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 conducted on 27 June 2023, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* The provider responded to the Notice of Non-compliance issued by Compliance on the 7 July 2023, with their Remediation Action Plan on 14 July 2023 and 21 July 2023, however not separately to the Assessment Team report. The response to compliance has been considered for the provider’s response to the Assessment Team’s Report
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Undertaking to Remedy Non-compliance issued 7 August 2023, Non-compliance Notice issued 7 July 2023 following Assessment Contact conducted 27 June 2023, Assessment Team report following Assessment Contact conducted 27 June 2023, Performance Report dated 7 February 2022 following Site Audit conducted 14 December to 16 December 2021.

**Assessment summary**

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

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 2(3)(e)  The approved provider must demonstrate that incident investigation and root cause analysis are conducted following an incident to ensure effective assessment and planning to prevent future incidents.
* Requirement 3(3)(b) The approved provider must demonstrate that there is effective management of high impact or high prevalence risks to respond to incidents or deterioration and that interventions are reviewed to measure the effectiveness of the interventions to prevent the risks from reoccurring.
* Requirement 7(3)(e) The approved provider must demonstrate that there is effective oversight and monitoring of staff performance and that all staff have the appropriate induction and orientation to the service to undertake their role.
* Requirement 8(3)(c) The approved provider must demonstrate that there are effective organisation wide governance systems for information management, continuous improvement, workforce governance, regulatory compliance, feedback and complaints and financial governance and that the actions committed to in the Plan for Continuous Improvement are delivered, reviewed and evaluated for effectiveness
* Requirement 8(3)(d) The approved provider must demonstrate that there is effective risk management systems and practices, for managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system and that the actions listed in the Plan for Continuous Improvement are delivered, reviewed and evaluated for effectiveness.

**Standard 2**

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| 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 |
| 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. | Non-compliant |

**Findings**

The Quality Standard has been found to be Non-compliant as one of the specific requirements have been assessed as Non-compliant.

The following requirement 2(3)(d) was found to be Compliant.

This requirement was found to be Non-compliant at the last Site Audit in December 2021 as consumers were not offered a copy of their care plan and were unaware, they could request it. During this Assessment Contact the service was able to demonstrate that these issues have been effectively addressed and the outcomes of assessment and planning are effectively communicated to the consumers and their representatives and documented in an electronic care planning system.

The Assessment Team interviewed consumers and representatives who advised that they have received a copy of their care plan and feel comfortable advising staff if there is incorrect information.

The Assessment Team identified that the services’ electronic care planning system allows both a summary or a detailed care plan to be exported, printed and provided to any consumer or representative if they wish. Improvement activities undertaken since the previous Site Audit have involved informing all consumers about their right to receive a copy of the outcomes of assessment and planning and how to request alternative methods of communication is that is desired.

The following requirement 2(3)(e) was found to be Non-compliant.

This requirement was found to be Non-compliant at the last Site Audit in December 2021 as reviews and assessments were not always conducted when circumstances change, or incidents occurred. These deficiencies have not been effectively addressed by the service and during this Assessment Contact it was found that while assessments and care plans are reviewed following incidents, these reviews do not include investigation of factors which may contribute to incidents, review of the effectiveness of existing interventions and new interventions were not evident when consumers experienced ongoing incidents. It was not evident that changes in a consumer’s condition triggers the need for a review of existing interventions.

The Assessment Team found that while assessments and a care plan review were undertaken following a consumer’s fall, consideration of the impact of hypotension on the consumer’s falls risk was not considered when the consumer became hypotensive or following the fall. Lack of incident investigation and root cause analysis following the consumer’s fall inhibits the service’s ability to ensure effective assessment and planning to prevent future incidents. The Assessment Team identified an absence of interventions in response to ongoing falls. Some interventions to prevent falls, such as increased surveillance, do not provide guidance about how this should be achieved or monitored.

An action plan was developed by the service in response to deficiencies identified in the previous Site Audit report. The actions identified largely focused on actions for individual consumers and advised staff of the organisation’s process for assessment and planning. There has not been an evaluation of the effectiveness of the planned actions.

The approved provider responded to the Notice of Non-compliance and this was considered as the response to the Assessment Team report. The provider included a Plan for Continuous Improvement, actions and evidence of actions taken which include education on assessment and planning delivered on-site by the clinical nurse educator from the week commencing 17 July 2023. The Quality and Clinical Governance Team have commenced a review of high-risk consumers at service including consumers having frequent falls, behaviours, and chronic wounds to ensure appropriate interventions are being trialled and evaluated. Findings from the initial reviews have been shared with the local management team and where appropriate, added to the Plan for Continuous Improvement, all consumers are to be reviewed by 30 September 2023. The Quality and Clinical Governance Team will be introducing a new automated high-risk consumer register by 31 August 2023 which will assist all homes to identify and manage risks. In the interim, the clinical team will be using the Falls, Risk and Safety Report from the care planning system to support discussion at weekly care planning meetings about changes in care needs across 29 clinical indicators.

I acknowledge the approved provider’s response, however, understand that it will take some time to reflect sustained compliance with this requirement, following a full review of consumers by end of September 2023.

I find that the approved provider is Non-compliant with requirement 2(3)(e).

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

**Findings**

The Quality Standard has been found to be Non-compliant as one of the specific requirements have been assessed as Non-compliant.

The following requirement 3(3)(b) was found to be Non-compliant.

This requirement was found to be Non-compliant at the last Site Audit in December 2021 as risk interventions did not adequately minimise and manage risks to each consumer. During this Assessment Contact it was again found that interventions were not effective in minimising risks and that planned interventions were not followed. Effective and appropriate interventions following incidents does not always occur. This includes lack of comprehensive assessment, monitoring for pain and monitoring for clinical deterioration.

The Assessment Team identified that staff did not manage high impact high prevalence risks appropriately or respond to an incident or deterioration effectively for one consumer. Falls have not been managed appropriately with a lack of successful interventions implemented. It was identified that neurological and pain monitoring in accordance with the organisation’s procedures did not occur for sampled consumers, falls prevention measure of hip protectors were not implemented. Recommendation for medical review by the dietitian was not followed up. There were gaps in monitoring a consumer’s blood pressure and wound and there was no ongoing monitoring following the identification of possible cellulitis.

The service developed an action plan in response to issues identified in the previous Site Audit report. The improvement measures focused on improving interventions for consumers with behavioural support requirements. There was no evaluation of the effectiveness of the planned actions in ensuring that high impact and high prevalence risks.

The service is experiencing a high number of falls. Organisational management said they are aware of issues related to appropriate incident management and failure to investigate incidents. Organisational analysis of May 2023 incidents includes measures to manage high impact and high prevalence risks for some individual consumers, however, these have not yet been implemented.

The approved provider responded to the Notice of Non-compliance and this was considered as the response to the Assessment Team report. The provider included a Plan for Continuous Improvement, actions and evidence of actions taken which include education provided to clinical staff on the deteriorating consumer, daily huddle for care and clinical staff to improve communication and timely escalation of any care need changes and deterioration, daily reminders of high-risk high prevalence consumers to be included at handover and huddle with all staff which includes all consumer that are unwell and at high risk of incidents. Review of continence assessments for consumers in Bushmaster, review the staffing allocation on the morning shift to ensure all consumers are attended in a timely manner.

I acknowledge the actions that the approved provider has initiated, however understand that it will take some time to reflect that staff have the knowledge and training to prevent high impact and high prevalent risks and that the interventions are effective.

I find that the approved provider is Non-compliant with requirement 3(3)(b).

**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. | Non-compliant |

**Findings**

The Quality Standard has been found to be Non-compliant as one of the specific requirements have been assessed as Non-compliant.

The following requirement 7(3)(a) was found to be Compliant.

This requirement was found to be Non-compliant at the last Site Audit in December 2021 as feedback from consumers, representatives and staff indicated there was not enough staff to meet consumer care needs at the service. While management had a number of recruitment strategies in place, a review of roster documentation by the Assessment Team showed a significant number of unfilled shifts.

During the Assessment Contact conducted on 27 June 2023 the Assessment Team found that the actions taken in response to the Non-compliance have been effective. Most consumers and representatives interviewed indicated they are happy with care at the service and there are enough staff to meet their needs. The service demonstrated how it plans the workforce to ensure it meets the needs of consumers. While some staff said they ‘work short’ one or 2 shifts per week, feedback and review of care and services documentation, and interviews with consumers and representatives did not indicate any negative impact on consumers.

The following requirement 7(3)(e) was found to be Non-compliant.

This requirement was found to be Non-compliant at the last Site Audit in December 2021 as the service was unable to demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce was undertaken. Staff interviewed were unable to describe the performance appraisal process. The service has now ensured annual performance appraisals occur. However, during this Assessment Contact deficiencies were identified in ensuring the induction process is effective and ongoing monitoring and review of staff performance occurs to ensure staff are appropriately delivering care and services.

The Assessment Team identified that the service failed to appropriately train and monitor staff performance to ensure that high impact risks related to consumers were managed. Management identified that issues with orientation of agency staff and care staff handover was deficient. They said while a handover of information about consumer needs occurs staff have said they don’t understand the information provided to them. Feedback received from agency staff was that they did not feel there was adequate induction provided by the service.

The service has implemented actions in response to the Non-compliance identified at the previous Site Audit. A new electronic appraisal system was completed where managers receive electronic prompts to initiate performance reviews for staff on their employment start date anniversary. The service provided information to demonstrate annual performance appraisals occur and staff confirmed they had been involved in staff appraisal processes.

The approved provider responded to the Notice of Non-compliance and this was considered as the response to the Assessment Team report. The provider included a Plan for Continuous Improvement, actions and evidence of actions taken which include leadership training for registered nurses to empower them to better manage care staff and ensure compliance with protocol, buddy orientations and inductions sessions with permanent staff to be conducted for all agency staff with online learning modules and induction video specifically available for agency staff, toolbox talks for staff on caring for consumers who smoke, training on high impact high prevalence and monitoring performance to ensure compliance.

Whilst I acknowledge the actions that the approved provider has committed to, I understand that it will take time to demonstrate sustained compliance to ensure that staff performance is monitored effectively.

I find that the approved provider is Non-compliant with requirement 7(3)(e).

**Standard 8**

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| 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. | Non-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. | Non-compliant |

**Findings**

The Quality Standard has been found to be Non-compliant as two of the specific requirements 8(3)(c) and 8(3)(d) have been assessed as Non-compliant.

These requirements were found to be Non-compliant at the last Site Audit in December 2021 as the service was unable to demonstrate its governance systems, including information management, workforce governance and regulatory compliance were working effectively. The Assessment Team identified that staff were unable to describe how to access policies, some policies did not reflect current regulatory changes and there was a general lack of document and policy control. The organisation was unable to demonstrate that there was an effective risk management system at the Site Audit in December 2021. While there were systems for managing risks, the organisation had not ensured these were always implemented at the service. During this Assessment Contact it was found that the organisation has policies and procedures related to risk management. However, the implementation of risk management has not been effectively undertaken and monitored at the service resulting in risks to consumers.

While the specific issues identified during the previous Site Audit have been addressed, during the Assessment Contact conducted on 27 June 2023 the Assessment Team identified deficiencies in relation to information management, continuous improvement, workforce governance and regulatory compliance. The service demonstrated it has effective governance systems in place relating to financial governance and feedback and complaints.

The Assessment Team identified that although a number of actions had been taken in relation to information management, long term deficiencies in relation to a lack of incident investigation does not ensure that staff are provided with all the relevant information to inform the development of effective care plans. These deficiencies were identified at the previous Site Audit at the end of 2021 and have not been addressed by the organisation’s systems.

The Assessment Team identified that although a number of actions had been taken in relation to continuous improvement, the service was unable to provide the service and organisation’s Plan for Continuous Improvement when requested during the Assessment Contact. The chief clinical advisor indicated he had been working on the documents and they were having technical issues obtaining the data and would forward it directly following the Assessment Contact, however this was not received.

While some requirements found to be Non-compliant at the previous Site Audit have been addressed, the organisation’s processes for continuous improvement have not been effective in addressing issues related to requirements 2(3)(e), 3(3)(b), 7(3)(e) and 8(3)(d). The action plan developed to address the Non-compliance at the previous Site Audit largely focused on addressing individual issues rather than overall systemic issues related to the requirements. The plan did not include measures to evaluate the effectiveness of improvement activities. One area which was found Non-compliant at the last Site Audit, requirement 8(3)(d) did not include any improvement activities.

The Assessment Team identified that the organisation has clear roles and responsibilities assigned to each staffing department and has an organisational human resources department with oversight responsibilities in areas of workforce regulations, training and recruitment. Labour reports and employee analysis are conducted from the executive to the service through the organisational analysis application. The service manager has weekly meetings with the regional manager to discuss workforce challenges including the high use of agency staff. However, these processes have not identified the gap in training and monitoring of staff to ensure high impact, high prevalent risks are prevented.

The Assessment Team identified that the organisation has systems for ensuring the implementation of regulatory compliance obligations. However, while staff were familiar with SIRS reporting. Management at the service did not demonstrate understanding of the requirements for SIRS reporting, following feedback from a representative that was not reported as SIRS incidents.

The organisation demonstrated it has an effective financial governance system with an organisational finance committee that is responsible for financial governance processes within the organisation. The regional manager is assigned to ensure expenditures at the service are within organisational budget. There are processes in place to purchase out of budget items when required at the service and a business plan is submitted as required.

The organisation demonstrates feedback and complaints are monitored at organisation level through an organisational analysis application. A new compliance and accreditation manager role has been created at organisation level to monitor and respond to complaints at service level and escalate to the executive and board as required.

The Assessment Team found that the organisation has not effectively managed environmental risks and staff practices to ensure the safety of consumers who smoke. The Assessment Team observed that the smoking area at the service is the same area that is used by non-smokers for relaxation and does not provide any separation to prevent passive smoke risks. The seating has plastic type coverings on seat cushion and back rests. Several very small ashtrays, which may be difficult for someone with dexterity issues to use, were on tables. Management said there had been no risks assessment undertaken on the smoking area or any processes such as audits to identify the risks to consumers.

The organisation has not ensured that management at the service is familiar with, and implements, SIRS reporting requirements.

The action plan developed following the Site Audit at the end of 2021 did not include any consideration of the possible systemic issues related to risk management and deficiencies in management of high impact and high prevalence risks continue to be an issue at the service.

The organisation has recently implemented improvements to processes for monitoring clinical risks and incident management across the organisation which includes escalation of information about risks through the organisation. However, to date these measures have not resulted in improvements in the management of risks at the service.

The approved provider responded to the Notice of Non-compliance and this was considered as the response to the Assessment Team report. The provider included a Plan for Continuous Improvement, actions and evidence of actions taken which includes incident management and investigation training provided to staff, a full review to be completed of all current open incidents to ensure comprehensive review of the effectiveness of current strategies and incorporate new strategies, review of ‘Riskman’ to update the investigation fields to include more prompts to support staff in completing investigations and understand root cause of incidents and establishing effective preventative measures. All clinical staff are to attend the Commission’s Virtual Education session- Effective Incident Management Systems (IMS) and the Serious Incident Response Scheme (SIRS) and attend SIRS Incident management and investigation training provided to all clinicians by Clinical Governance Education Team. The Quality and Clinical Governance Team will allocate a team member to provide support within the home to ensure ongoing monitoring and evaluation of improvement activities with reports and findings tabled at weekly remediation plan meetings. Fire Training for all staff with a reminder memo to all staff to ensure that the designated area is used for smoking and regular spot checks are conducted for compliance. The provider has also committed to undertake risk assessments and address identified gaps.

I have considered the information and actions included in the Plan for Continuous improvement, however, understand that it will take time to reflect compliance in these requirements.

I find that the approved provider is Non-compliant with requirements 8(3)(c) and 8(3)(d).

1. The preparation of the performance report is in accordance with section 68A Assessment Contact of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)