Performance

Report

**1800 951 822**

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| Name of service: | Acacia Living Group Meadow Springs Aged Care Facility |
| Service address: | 82 Oakmont Avenue MANDURAH WA 6210 |
| Commission ID: | 7154 |
| Approved provider: | Acacia Living Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 31 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 Acacia Living Group Meadow Springs Aged Care Facility (**the service**) has been prepared by M Glenn, 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.

# 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 and representatives;
* the provider’s response to the Assessment Team’s report received 7 August 2023; and
* the Performance Report dated 18 January 2023 for a Site Audit undertaken from 6 December 2022 to 8 December 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | 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 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** |
| **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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate all consumers are treated with dignity and respect. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Staff training targeted at dignity and respect.
* Increased oversight by management and setting of clear expectations of behaviour for all staff.
* Conducting investigations and enacting disciplinary action in cases where staff behaviour has been identified as being unacceptable.

At the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, consumers were observed to be treated with kindness, dignity, and respect by staff. Staff demonstrated familiarity with consumer backgrounds and specific strategies implemented to maintain their identity, culture and diversity. Consumers feel like they are treated with dignity and respect, with their identity, culture and diversity valued.

For the reasons detailed above, I find requirement (3)(a) in Standard 1 Consumer dignity and choice compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate consumers’ needs and preferences were documented in care plans. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* A full review of all diabetic management plans to ensure plans are up to date.
* Implementation of improved clinical handover processes.
* Introduction of a mid-morning staff huddle where changes to consumers’ care are communicated.

At the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, documentation showed entries from general practitioners, allied health and summaries of specialist reports were communicated effectively within the organisation and with external providers where appropriate. Staff are satisfied they receive the information they need to be able to provide effective care to consumers and consumers and representatives feel they are informed of any changes in the delivery of care or when incidents or event occur.

For the reasons detailed above, I find requirement (3)(e) in Standard 3 Personal care 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

The service demonstrated meals are varied and are of suitable quality and quantity. However, some consumers stated that whilst they eat the main meals, they find them generally disappointing. Consumers who reported they did not like the food were able to give several examples of where the kitchen has made changes to ensure they receive food they like, and individual consumer satisfaction is followed up at the food focus group. Consumers are involved with creating the menu which is checked by a dietician to ensure the appropriate nutritional content. Observations showed care staff interacting positively with consumers and assisting them with meal time activities.

For the reasons detailed above, I find requirement (3)(f) in Standard 4 Services and supports for daily living 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirements (3)(c) and (3)(d) were found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate appropriate action was taken following complaints by consumers and representatives, nor were complaints reviewed to improve the quality of care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Introduction of an electronic feedback system to review and track actions taken in response to feedback and complaints.
* Feedback management training for staff.
* Multidisciplinary meetings where improvements are discussed following complaints and feedback.

At the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, staff and management described the open disclosure process and provided examples of where it had been used. Documentation showed appropriate action taken to resolve a complaint made about food to the satisfaction of the consumer. Consumers and representatives felt satisfied staff and management respond appropriately when issues are raised.

The organisation has processes in place to ensure all feedback and complaints are captured, analysed, trended and reviewed, to identify areas of improvement. Management provided examples of improvements made throughout the service in relation to consumer feedback, and consumers and representatives confirmed improvements have been implemented in response to their feedback and complaints.

For the reasons detailed above, I find requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements (3)(b) and (3)(e) were found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate the workforce always acted in a kind, caring and respectful way, or that staff performance was regularly monitored and evaluated. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Staff training to reinforce positive culture and behaviour.
* The undertaking of a consumer experience and satisfaction survey and staff satisfaction survey.
* Improvements demonstrated in following up with individual staff following complaints and feedback relating to poor care practices.
* Staff appraisals being undertaken annually.

At the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, staff provided examples of how they deliver consumer centric care in a kind, caring and respectful manner, and were aware of escalation processes should they witness unkind or disrespectful care being provided. Caring interactions between staff and consumers was observed. Consumers feel regular carers know them well and are considerate in all their interactions.

Regular assessment and review of staff performance is undertaken on each member of the workforce and processes include prompt responses to staff misconduct. Management monitor staff performance through peer feedback, complaint data and audits. Staff confirmed they undertake regular performance reviews where they can identify their personal strengths and areas for improvement. Consumers felt staff were competent and performed their caring roles well.

For the reasons detailed above, I find requirements (3)(b) and (3)(e) in Standard 7 Human resources compliant.

# 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. | 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 (3)(c)**

Requirement (3)(c) was found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate effective information management systems and practices to ensure staff received timely information about consumers’ care needs. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Improved handover processes and new electronic feedback and incident management systems.
* New share point page, accessible to all staff which houses all governing policies and procedures.
* Refresher training, key areas of focus and legislative updates as identified by the governing body are provided to all staff.

At the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, continual improvement processes address areas identified for improvement. The information governance framework policy outlines communication processes, safe handling, access, storage, and destruction of sensitive information and the communication of legislative requirements. Financial governance outlines spending approval and delegations, and all positions have job statements which articulate job roles, responsibilities and accountabilities for each member of the workforce. Management demonstrated how feedback was captured and used to identify areas of improvement and processes are in place to electronically receive complaints and feedback.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance compliant.

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 6 December 2022 to 8 December 2022 where it was found the service did not demonstrate incidents were investigated and recorded, staff were equipped with information to effectively identify, report of manage high impact risks, or allegations of abuse were recognised and responded to. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, implementing a new incident management system, and providing training to staff.

However, at the Assessment Contact undertaken from 11 July 2023 to 12 July 2023, the Assessment Team were not satisfied effective risk management systems and practices relating to managing high impact or high prevalence risks, supporting consumers to live the best life they can and managing and preventing incidents were demonstrated. The Assessment Team recommended requirement (3)(d) not met and provided the following evidence relevant to my finding:

* Effective governance systems were not demonstrated in relation to using data about high impact or high prevalence risks to reduce the impact to consumers or identify strategies to mitigate risks to consumers when they are undertaking activities of choice.
* Incident investigations did not seek to identify root causes and identify actions to prevent reoccurrence, resulting in consumers being at risk of ongoing harm.
  + Consumers A and B received and choked on food that was not consistent with their modified diet requirements.
  + Ten consumers were reported with a greater than 3kg weight loss in the last 3 months. Staff could not describe what investigation had been undertaken to identify the root cause of this, resulting in the implementation of generalised strategies, such as the provision of supplements, rather than targeted actions addressing the cause of the consumer’s weight loss.
* No effective risk mitigation/alternative strategies documented for Consumer C’s risk choice assessment.
* Whilst the service reported monthly clinical indicators, staff could not describe or demonstrate how this data is used to drive improvement actions in relation to managing high impact or high prevalence risks for consumers.

In the provider’s response, the provider stated the service has implemented improvements in incident management, inclusive of staff training in high impact or high prevalence risks. The risk management system identifies and evaluates incidents which are recorded and analysed monthly to monitor the effectiveness of care provision and improve processes where required. Clinical incidents are trended and analysed by the service and discussed at staff meetings, and actions are taken if a risk has increased. At an organisational level, this information is discussed monthly, with risk indicators reviewed and discussed to inform the plan for continuous improvement.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. I have considered that while there were some deficits identified by the Assessment Team, the service has undertaken measures to review, update and implement appropriate strategies to minimise risk. I have also considered that the deficits identified do not demonstrate systemic issues relating to the service’s overall risk management systems and practices. In coming to my finding, I have placed weight on the fact that documentation included in the provider’s response for Consumers A and B describes strategies to mitigate risks to the consumers while supporting them to live the best life they can, and Consumer C has had a full reassessment and all relevant strategies are now in place which respects their choices. Staff have undertaken further training in gaps identified for modified foods and diets, and the plan for continuous improvement includes strategies to manage unplanned weight loss of consumers.

In coming to my finding, I have also considered evidence included in the Assessment Team’s report demonstrating there are policies and procedures to assist and guide staff with managing high impact or high prevalence risks. High impact or high prevalence risks are tracked through a clinical indicators audit form which has been expanded to include a breakdown of individual incidents to improve trend tracking and identify learning needs at a strategic level, which flows back through the wider organisation. There are policies, systems and practices to support consumers to live their best lives, including undertaking risks, and duty statements outline individual responsibilities for reviewing and recording consumer risk choices. Policies and procedures assist staff in identifying and responding to incidents of abuse and neglect of consumers, and learning records show all staff have undertaken Serious Incident Response Scheme training as part of the service’s core training standards.

For the reasons detailed above, I find requirement (3)(d) 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)