Performance

Report

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| Name: | Acacia Living Group Menora Gardens Aged Care Facility |
| Commission ID: | 7151 |
| Address: | 51 Alexander Drive, MENORA, Western Australia, 6050 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 12 August 2024 to 13 August 2024 |
| Performance report date: | 27 August 2024 |
| Service included in this assessment: | Provider: 1599 RSL Care RDNS Limited  Service: 4679 Acacia Living Group Menora Gardens Aged Care Facility |

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 Menora Gardens 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 (performance assessment) – site, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* a performance report dated 18 July 2023 for a site audit undertaken from 15 May 2023 to 17 May 2023.

The provider did not submit a response to the assessment team’s report.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not fully assessed |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 4** Services and supports for daily living | **Not fully assessed** |
| **Standard 5** Organisation’s service environment | **Not fully assessed** |
| **Standard 6** Feedback and complaints | **Not fully assessed** |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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 in May 2023 as each consumer was not treated with dignity and respect. In response to the non-compliance, the provider has implemented a range of improvement actions, including increasing staff learning and development opportunities on treating consumers with dignity and respect, including in relation to continence care and meal assistance; and undertaking internal auditing to identify potential gaps in care and service provision relating to consumers’ individual and cultural needs.

At the assessment contact undertaken in August 2024, consumers and representatives said staff always treat consumers with respect and dignity. Information about consumers’ identity, including personal history and cultural background is recorded and used to guide provision of person-centred, tailored care. Management and staff described the importance of getting to know consumers individually and providing respectful and dignified care which meets their individual needs and preferences. Staff said they have received training in providing personalised care and services and treating consumers with respect and dignity, and described how they ensure personalised, dignified, and respectful care is provided to consumers. Throughout the assessment contact, management and staff were consistently observed treating consumers with dignity and respect.

Based on the assessment team’s report, 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)(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. | 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 |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

**Requirements (3)(a), (3)(b), (3)(d) and (3)(g)** were found non-compliant following a site audit undertaken in May 2023 as each consumer did not receive safe and effective personal care that was best practice or which optimised their health and well-being; high impact or high prevalence risks associated with care, specifically pain, falls and use of restraint were not effectively managed; changes in consumers’ condition and deterioration was not recognised or responded to in a timely manner; and appropriate infection control practices to minimise transmission of infections were not demonstrated. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, staff training on continence, falls, restrictive practices, clinical deterioration, hand hygiene and donning and doffing of personal protective equipment; reviewed continence practices; a high impact high prevalence risk register and a restrictive practice register; daily clinical huddles to identify and implement strategies for consumers considered at risk; and strengthened existing infection prevention and control (IPC) audit processes.

At the assessment contact undertaken in August 2024, consumers were receiving personal and clinical care, which was safe, tailored to their needs, optimised their health and well-being and aligned with best practice and the service’s policy requirements. Care files sampled evidence effective, best practice care provision relating to diabetes, wounds and pain. There are processes to identify, assess, plan for, manage and review risks relating to consumers’ care. Care files sampled evidence effective management of risks relating to falls and behaviours, as well as involvement of general practitioners and allied health professionals in the assessment, management and review of consumers’ identified risks. Staff described the main risks for consumers and how these risks are identified, escalated and managed. Consumers and representatives are happy with the way staff assist consumers with their personal care needs, and said staff have undertaken appropriate actions to assess, reassess and review consumers’ needs, including following falls and when they experience pain.

A clinical deterioration policy guides clinical and care staff towards recognising when a consumer’s health and well-being may be deteriorating, and provides the process staff need to follow to assist with maintaining or restoring a consumer’s health and well-being. Care files show deterioration or changes to consumers’ condition are recognised and responded to in a timely manner, including initiating referrals to general practitioners, nurse practitioners, and allied health professionals or, where required, transferring consumers to hospital.

The service has an effective IPC program that aligns with nationally recognised guidelines and applicable governing standards. Three senior clinicians are designated IPC leads and are responsible for overseeing training and monitoring of staff practice. Corporate IPC staff provide support and assist clinical staff to monitor and support care staff to undertake IPC related precautions, including suitable use of personal protective equipment and appropriate donning and doffing procedures, when required. Antibiotic therapy is only prescribed when a consumer is symptomatic, returns a positive pathology result for infection or has a history of infection related illness. Consumer infections are monitored, and a report is reviewed monthly by management to monitor and target trends. All care staff said they have received IPC related training and understand the precautions to be followed to minimise risk of infection. Staff said they have access to an adequate supply of personal protective equipment to help prevent cross infection and are supported by clinical staff when required. Consumers said they observe staff undertaking hand hygiene where this is appropriate, for example, before and after care and during the meal service.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(d) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

**Requirements (3)(a), (3)(c) and (3)(f)** were found non-compliant following a site audit undertaken in May 2023 as the lack of engagement, meaningful resources and staffing did not meet consumers’ needs, goals, and preferences; each consumer was not supported to do things of interest to them or participate in the service’s community; and meals were not of suitable quality, and the dining experience for consumers residing in the memory support unit was not positive or enjoyable. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, internal auditing to identify gaps and opportunities for improving consumers’ well-being and quality of life; reviewed care plans to ensure currency of consumers’ needs, goals and preferences; a lifestyle framework which supports and guides staff in promoting consumer independence, well-being and quality of life, and provides guidance and support to staff in providing a variety of activities; a food focus group to increase consumer engagement and feedback on the menu, and dining experience; a hospitality coordinator with oversight of the meal service and dining experience; and additional training and support for staff in providing a welcoming dining experience and respectful meal service.

At the assessment contact undertaken in August 2024, consumers were receiving supports for daily living which met their needs, goals and preferences and optimised their independence and well-being. Care files show consumers are assessed and identified supports are provided to assist consumers to maintain their independence and optimise their well-being and quality of life. The allied health team described how they focus on maximising consumers’ independence and well-being in line with their needs goals and preferences, including through prescribing assistive and adaptive equipment, mobility aids, exercise plans and walking programs.

Consumers and representatives said there are opportunities for consumers to participate in planned activities, have one-to-one engagement with staff, and to have personal and social relationships with people of importance to them within the service and externally. Care plans outline consumers’ interests and activities they wish to participate in. Staff record consumers’ participation and engagement levels, seek consumer feedback post activity and evaluate effectiveness/suitability of the activity. Throughout the assessment contact, consumers were engaged in a variety of planned activities, and one-to-one engagement with staff.

Consumers said they are satisfied with the menu, can make alternate choices, enjoy the dining experience and can provide feedback for improvements. During meal service in each area, consumers were eating their meals either in their rooms as they preferred, or in a welcoming, calm environment. Consumers were offered meals in accordance with their preferences and dietary requirements, were offered choice and could select alternative options, including items not on the menu. Food focus group minutes and the feedback register show consumers are supported to provide feedback about the quality, quantity and variety of meals, and improvements are made to the menu and dining experience as a result.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c) and (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)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| 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

**Requirements (3)(a) and (3)(b)** were found non-compliant following a site audit undertaken in May 2023 as the memory support unit environment was not welcoming or easy to navigate, and the lack of furnishings and brightness did not provide a sense of belonging; and the memory support unit environment was not clean, safe, well maintained, or comfortable. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, commissioning an architect to develop plans for the redesign of the building to improve function, independence, and interaction opportunities; commissioning an external provider to conduct an audit to provide advice on a dementia enabling environment, to be considered in the redesign and refurbishment; improved and increased cleaning schedules, including additional shifts; and removed stained, worn furniture and purchased new furniture.

At the assessment contact undertaken in August 2024, the service environment was welcoming, homely and easy to navigate, and clean, well maintained, and comfortable. Doors to the outdoor environment are unlocked, and consumers were accessing outdoor gardens on their own or with support from staff. Consumers and representatives said the service environment is welcoming, and consumers have spaces for group interaction and quiet reflection. Consumers said they like their rooms and can bring in their own furniture and personal items from home to decorate their rooms.

Representatives with relatives living in the memory support unit said staff do their best to keep the environment clean and they are pleased to hear of the redesign and refurbishment of the service environment. Cleaning of consumer rooms and common areas is undertaken in line with a task list and cleaning schedule, and maintenance processes are in place. The memory support unit environment requires refurbishment, including painting, replacement of furniture and floor coverings, however, redesign and refurbishment of building has been budgeted for, and is in process. A complete redesign and refurbishment will be completed in consultation with consumers and their families, and will include painting, floor covering replacement, furniture, including tables, chairs and equipment, with aesthetics in line with dementia enabling environment principles. The provider has made attempts to improve the environment in the interim, including removing worn/stained chairs, introducing plants and a fish tank to create a more welcoming environment, and enhancing the cleaning schedule.

Based on the assessment team’s report, I find requirements (3)(a) and (3)(b) in Standard 5 Organisation’s service environment 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 in May 2023 as appropriate action was not taken in response to complaints; and feedback and complaints were not used to improve the quality of care and services. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, reviewed feedback and complaints for a six-month period and captured areas for improvement; reviewed processes and responsibilities for feedback and complaints management; and responded to and addressed areas of concern relating to consumer care and services.

At the assessment contact undertaken in August 2024, consumers and representatives were satisfied reasonable action is taken to address any concerns raised, and said staff keep them informed of changes and improvements. Staff and management are guided in complaints management through policies and procedures which outline open disclosure and roles and responsibilities for accountability. Staff interviewed described their roles and responsibilities for documenting complaints and feedback, and documentation demonstrates open disclosure principles are applied in response to feedback and complaints.

Staff interviewed described their roles and responsibilities for addressing, capturing and reporting feedback, complaints and compliments raised during provision of care. Feedback and complaints are tracked, trended and analysed, with opportunities identified for process improvement. The service’s governing body supports process improvement through additional oversight and review of trending complaints and feedback. Consumers and representatives said in response to concerns raised, they have noticed improvements in care and services.

Based on the assessment team’s report, 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)(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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

**Requirements (3)(a), (3)(c), (3)(d) and (3)(e)** were found non-compliant following a site audit undertaken in May 2023 as the service did not have the right number or mix of staff to deliver safe and quality care, particularly to consumers in the memory support unit; the workforce was not competent nor did they have the qualifications and knowledge to effectively perform their roles; the workforce had not received training in the areas where deficits were identified, including restrictive practices and recognising deterioration; and regular assessment, monitoring or review of the performance of each member of the workforce was not undertaken. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, changes to the current roster and allocation of vacant shifts into permanent lines; increased the number of staff working across all areas; a registered nurse development day which included topics, such as wound management, deterioration and behaviours; monthly registered nurse meetings to discuss clinical matters and concerns; education to staff on restrictive practises and the serious incident response scheme (SIRS); and completed all outstanding appraisals.

At the assessment contact undertaken in August 2024, systems and processes were found to be in place to ensure the number and mix of staff is sufficient to enable the delivery and management of care and services. A roster is maintained and the workforce is planned based on minutes of care required for each consumer, and there are processes to manage planned and unplanned staff leave. A registered nurse is available on each shift. Staff members from various disciplines said there are enough staff available to meet consumers’ needs and they have enough time to do their job. Consumers and representatives interviewed said there are enough staff, including in the memory support unit, and consumers do not have to wait a long time for their call bell to be answered.

Consumers and representatives said staff are competent in providing care and services and they are suitably trained in their roles. Position descriptions outline minimum qualification requirements and duty statements guide staff in their roles. There are processes to monitor currency of staffs’ professional registrations and police clearances. New staff members complete orientation prior to starting to work and undertake a minimum of two buddy shifts. All staff attend annual mandatory education, and education records show all but one staff member has completed mandatory education requirements. A variety of education toolbox meetings have been provided in the last three months on topics, such as hand hygiene, donning and doffing of personal protective equipment and medication competency. Staff described recruitment and orientation processes, and said they receive ongoing education related to their role.

Regular assessment, monitoring, and review of the performance of each member of the workforce is undertaken. Staff performance appraisals occur at three and six months during the probation period, then annually, with performance management processes undertaken where issues with staff performance are identified. There are currently eight outstanding appraisals and management have been in contact with these staff members to arrange a time for completion. Staff practice is monitored ongoing and additional training needs identified through direct observation, feedback processes, incidents, and performance appraisals.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

**Requirements (3)(b), (3)(c), (3)(d) and (3)(e)** were found non-compliant following a site audit undertaken in May 2023 as the organisation’s governing body did not promote a culture of safe, inclusive and quality care services and were not accountable for their delivery; there were systemic failures in governance systems relating to workforce and feedback and complaints; risk management systems relating to high impact or high prevalence risks and incident management were not effective; and the clinical governance framework, specifically relating to minimising use of restraint and antimicrobial stewardship was not effective. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, adding the service to the internal home for improvement group for additional oversight and support; on the ground support to uplift capability and knowledge, and increased resources at a site level; projects relating to human resources review, onboarding and uplift; capability uplift for high impact high prevalence risks and incident management; reviewing oversight practices, including meeting and reporting requirements; and reviewing IPC practices.

At the assessment contact undertaken in August 2024, the governing body was found to promote and support a culture of safe and inclusive quality care and services. The organisation is supported by a board, and the organisation has departmental structures with appropriately skilled staff to support quality and strategic direction, including assessment of performance for each residential service. Reporting processes from service management to the board ensures effective oversight of trends analysis, quality reviews, and support for continual improvement. Meeting minutes, communication and analysis reports show the governing body identifies areas for improvement and liaises directly with the service, with strategies and supports to address identified deficiencies. A consumer advisory committee has been established, however, two expressions of interest did not result in any nominations from the service’s consumers.

There are effective organisation wide governance systems, including in relation to information management, continuous improvement, financial governance, workforce, regulatory compliance and feedback and complaints. Governance systems are supported by a suite of policies, procedures, support and analysis teams, and communication to ensure roles, responsibilities and systems are supportive of safe care and services. There are processes to monitor and review information management systems and practices, including care management systems and reporting tools. Weekly and monthly operational reports show the organisation supports the service with legislative updates, and policy changes. The organisation provides support to the service to address identified deficiencies of non-compliance, and management provided examples of regular updates provided to staff to support knowledge and changes relating to compliance. Additional support has been provided to the service to ensure continuous improvement strategies are implemented in a timely manner.

There are effective risk management systems and practices, including, but not limited to managing high impact or high prevalence risks; identifying and responding to abuse and neglect; supporting consumers to live the best life they can; and managing and preventing incidents. Assessments, planning and supports assist to identify and manage/mitigate high impact or high prevalence risks relating to consumers care. Incidents sampled, including serious incidents evidence root cause analysis and risk mitigation is undertaken for consumers, and related care documentation, assessments and planning are updated to minimise recurrence of similar incidents. Clinical indicator reports for the service for the past three months evidence a downward trend in major incidents, pressure injuries, physical restraint and unplanned weight loss. Staff interviewed described their roles and responsibilities for incident management, including escalation and serious incidents. Clinical managers said they are responsible for oversight of risk and incidents, including serious incidents for their residential areas, and described their responsibilities for incident and risk management which aligns with the service’s policies and procedures.

A clinical governance framework, supported by a suite of clinical policies and procedures, is in place. Medication advisory committee meeting minutes and incident reporting shows the service and governing body track infections and prescription of antimicrobials for analysis and review, and regular consultation is undertaken with the service’s prescribers. Staff have completed training on recognising restraint, and care documentation shows registered staff follow the service’s restrictive practice policy for chemical restraint and review to reduce use where possible and practicable. Records show physical restraint use has reduced over the past three months. All staff interviewed described open disclosure processes, and care documentation and incident management records show open disclosure principles are applied.

Based on the assessment team’s report, I find requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance 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)