Performance

Report

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| Name of service: | Akooramak Care of Older Persons |
| Service address: | 267-269 Wood Street WARWICK QLD 4370 |
| Commission ID: | 5084 |
| Approved provider: | Warwick Benevolent Society Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 |
| Performance report date: | 10 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 Akooramak Care of Older Persons (**the service**) has been prepared by P. Sherin, 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 staff, consumers/representatives, and others.
* the Provider’s response to the assessment team’s report received 28 July 2023 providing additional information.
* the site audit report for the site audit conducted 18 to 20 October 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 | **Non-compliant** |
| **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

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 4(3)(f) – Ensure meals provided are varied and of suitable quantity based on consumers’ individual needs and preferences.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

The service has taken action to remediate deficits as identified under the Site audit conducted 18 – 20 October 2022.

Consumers and representatives said consumers are supported to take risks and live the best life they can. Staff described how they support consumers who choose to take risks and the strategies implemented to ensure their safety. Care documentation demonstrated risk assessments have been completed and dignity of risk discussions with consumers and representatives have occurred.

The service was found to be non-compliant in the previous Site audit due to not demonstrating consumers who chose to take risks had been assessed; risks and benefits about potential harm had not been discussed with consumers and representatives; and management and clinical staff were not consistently aware of risks consumers chose to take. The service has implemented the following improvement actions to remediate these deficits:

* An audit of all consumers who choose to take risks has been undertaken to ensure appropriate assessments are completed and a record of the discussions and outcome documented under consumers’ care plans. Review of care documentation confirmed this has occurred for consumers who choose to engage in activities of risk including but not limited to the use of mobility scooters, bed poles and bed rails, and alcohol consumption.
* A dignity of risk register has been established and included on the service’s consumer risk register. This was sighted by the assessment team.

Based on the information recorded above, it is now my decision this Requirement is compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |

Findings

The service has taken action to remediate deficits as identified under the Site audit conducted 18 – 20 October 2022.

Consumers and representatives considered assessment and care planning delivered safe and effective care and services.

A range of validated clinical risk assessment tools are completed on entry and when a change to a consumer’s condition occurs. Registered staff described the assessment, care planning and review process, how they identify risks, and involve consumers in assessment and care planning.

Care planning documentation identified risks to individual consumers have been assessed and information on strategies to manage and mitigate these risks is captured to guide staff practice.

The service was found to be non-compliant in the previous Site audit due to not demonstrating consistent identification, assessment, communication, and consent for some risks individual consumers chose to engage in. The service has implemented the following improvement actions to remediate these deficits:

* An audit of all consumers who choose to take risks has been undertaken to ensure appropriate assessments have been completed and strategies to mitigate identified risks are reflected in consumers’ care plans. Review of care documentation confirmed this has occurred.

Based on the information recorded above, it is now my decision this Requirement is 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 |

Findings

The service has taken action to remediate deficits as identified under the Site audit conducted 18 – 20 October 2022.

Consumers and representatives provided positive feedback in relation to personal and clinical care received by consumers at the service. Staff demonstrated knowledge of individual consumers’ care needs and interventions in place to manage risks to their health and wellbeing. The service has clinical policies and procedures to guide staff practice in care delivery.

Care planning documentation identified consumers are receiving individualised care which is safe and right for them including in relation to wound care, falls, pain, continence care, and changed behaviours. Where restrictive practices are used, appropriate authorisation, consent, and behaviour support plans are in place. During the assessment contact, it was identified the service had not considered their locked perimeter as a form of environmental restrictive practice for consumers unable to operate the keypad code located at the service’s entrance. This was addressed by management who conducted an immediate review, secured verbal informed consent from consumers and representatives, and included an action item on the service’s continuous improvement plan to have the required documentation completed.

The service was found to be non-compliant in the previous Site audit due to consumer dissatisfaction with not receiving care in a timely manner resulting in adverse outcomes such as incontinence and falls; inconsistent compliance with restrictive practice regulatory obligations; and inconsistent completion of risk assessments. The service has implemented the following improvement actions to remediate these deficits:

* Training on restrictive practices, management of deterioration, and continence care has been provided to staff. Review of training records confirmed this has occurred.
* Falls management training is scheduled for all staff in August 2023.
* Restrictive practice registers have been developed and are maintained by clinical management and staff. Review of document folders located in each area of the service identified appropriate restrictive practice consent forms and authorisations.
* An audit of all consumers who choose to take risks has been undertaken to ensure appropriate assessments have been completed and strategies to mitigate identified risks are reflected in consumers’ care plans. Review of care documentation confirmed this has occurred.

Based on the information recorded above, and positive feedback received from consumers and representatives, it is now my decision this Requirement is 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. | Non-compliant |

Findings

The service did not demonstrate meals provided are meeting consumers’ preferences, are varied, and of suitable quantity.

The Assessment contact report brought forward feedback from several consumers who expressed dissatisfaction with the meals provided and said improvements have not been made in response to feedback. Consumers said meals specified on the menu are frequently not available and if meals include something they are unable to eat, they are not provided a substitute. Consumers provided examples of insufficient quantity of food being served. Some consumers said they do not express their concerns as they find other consumers providing negative feedback, and no change occurs.

Hospitality staff raised concerns regarding access to food and availability of menu options. Hospitality staff said the service ‘runs out of food’ frequently, there are no options for consumers requiring gluten free or lactose free snacks, and meals on the menu often change due to lack of ingredients. The catering manager said the menu has not been designed using consumer input, and improvements to the menu are not based on consumer feedback.

The Provider in its response submitted documentation to evidence a range of actions planned or implemented in response to the assessment team’s findings including, but not limited to:

* Fortnightly consumer/representative food advisory meetings commenced to seek ongoing consumer feedback and inform improvements.
* Individual consultations with consumers, including follow-up meetings with consumers identified as having raised concerns in the Assessment contact report.
* Dietary profiles are being reviewed to ensure these are in line with consumers’ current needs and preferences.
* The menu has been reviewed in consultation with consumers. A new Chef is due to commence mid-August 2023.
* Review of suppliers and processes to ensure adequate stock available on site. A specialised supplier has been engaged to provide options for consumers with specific dietary requirements.
* New processes implemented to limit changes to the menu and ensure timely communication to consumers.
* Photograph spot checks and electronic surveys utilised to ensure appropriate meal presentation, determine suitable mealtime preferences, and obtain real-time feedback from consumers.

As identified above, the service has taken immediate action to address the deficits identified in the Assessment contact report. I acknowledge the commitment of the Provider; however, I am of the view these new improvement measures and processes need sufficient time to be embedded within the service and to demonstrate their effectiveness and sustainability. Based on the information recorded above, it is my decision this Requirement is non-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)(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

The service has taken action to remediate deficits in the below Requirements as identified under the Site audit conducted 18 – 20 October 2022.

Requirement 7(3)(a)

Consumers considered there are enough staff at the service to meet their needs and staff attend quickly in response to call bells. Staff confirmed there is adequate staffing to provide care in accordance with consumer needs and preferences and said they generally have enough time to undertake their allocated duties. Management has contingency plans in place to replace staff when required and rosters are reviewed on a regular basis to ensure staff allocations are adequate.

The service was found to be non-compliant in the previous Site audit due to not demonstrating rosters are adequately filled; staff reporting they feel rushed and unable to complete their duties; and call bells not being answered in a timely manner. The service has implemented the following improvement actions to remediate these deficits:

* Staff rosters updated to fill all shifts by implementing multiple strategies including utilising new hires, overseas staff, student staff, and agency staff. Staff confirmed they have more time on shift to provide care and do not feel rushed.
* Increased staff shifts to ensure adequate coverage of shifts following staff feedback in February 2023.
* Implementing a new call bell system to enable management to review call bell data. Call bell data is now reviewed monthly with overlength calls investigated to prevent recurrence. Average response times for the month prior to the assessment contact identify response under 7 minutes.

Based on the information recorded above, and positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 7(3)(d)

Consumers and representatives said staff are well trained and know what they are doing. Staff described the orientation and onboarding processes, including mandatory training, competency assessments, and role-specific training. Staff said they are provided adequate training and support to equip them to perform their roles with confidence and can ask for further training if needed. The service implements a yearly training calendar on topics including but not limited to elder abuse, code of conduct, restrictive practices, and antimicrobial stewardship.

The service was found to be non-compliant in the previous Site audit due to low staff completion of mandatory training; the absence of a training register or calendar; and staff not being aware of available training. The service has implemented the following improvement actions to remediate these deficits:

* Staff completion of mandatory training ensured with review of documentation identifying 100% of staff have completed mandatory training.
* An annual training calendar established to provide staff training on role-specific and requested topics. Training sessions are made available over multiple days and times to ensure all staff are provided an opportunity to attend.
* Staff are now made aware of required training via emails, memos, and a digital application to ensure staff attendance.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 7(3)(e)

Management said staff performance is managed through regular performance appraisals and ongoing feedback.

Staff described their last performance appraisal process, said they feel supported in their role, and can request further assistance or training if required.

The service was found to be non-compliant in the previous Site audit due to staff being unaware of their position descriptions or able to recall having had a performance appraisal; management being unable to provide appraisal records; and registered staff stating they were unable to monitor staff. The service has implemented the following improvement actions to remediate these deficits:

* A performance appraisal register has been established to track staff appraisals. Review of appraisal records identified majority appraisals have been completed and those outstanding are scheduled for completion.
* Role descriptions have been circulated to staff and made accessible via a new human resourcing system. This was confirmed by staff.

Based on the information recorded above, it is now my decision this Requirement is 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 |
| 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

The service has taken action to remediate deficits in the below Requirements as identified under the Site audit conducted 18 – 20 October 2022.

Requirement 8(3)(a)

Management described how consumers are engaged in the development, delivery, and evaluation of care and services through monthly consumer meetings, surveys, feedback forms, and by speaking directly with management. Consumers said they considered the service is well run and they can provide feedback and suggestions to management, which are considered.

The service was found to be non-compliant in the previous Site audit due to decisions affecting consumers being made without consumer consultation or involvement. The service has implemented the following improvement actions to remediate these deficits:

* Expressions of interest have been sought from consumers and representatives to establish a consumer advisory committee. Whilst the service has not received strong interest, this will be placed as a standing agenda item at consumer meetings to continue to solicit interest.
* Consumer food advisory meetings are scheduled to commence in July 2023.
* Consumer meetings now occur regularly on the second Wednesday of each month. The meetings include an update from all department heads and an opportunity for consumers to provide feedback.

Based on the information recorded above, and positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 8(3)(c)

Staff confirmed consumer information is readily accessible within the organisation’s electronic care management system relative to their role. Staff said they have access to up-to-date policies, procedures, and training via the service’s electronic systems. Consumers and representatives were satisfied with the way information about care and services is managed and how information is provided to them.

Management advised opportunities for improvement are identified through a range of sources including but not limited to consumer/representative feedback, audit and survey results, clinical indicator trends, and incident data. Review of the service’s plan for continuous improvement identified planned and completed improvement actions in relation to care and service delivery.

A workforce governance framework supported by new systems and processes is in place to ensure adequate staffing levels, mandatory training completion, and regular staff performance appraisals.

The service was found to be non-compliant in the previous Site audit due to not demonstrating effective organisation wide governance systems in relation to information management, continuous improvement, and workforce governance. The service has implemented the following improvement actions to remediate these deficits:

* Roll-out of a new electronic system which holds policies and procedures in a centralised location. Staff confirmed they have access to this system and have received training to use it.
* The service is implementing a new electronic care management system and staff have access to training on how to use it.
* Handheld mobile computer devices have been provided to staff for ready access to consumer information. Staff confirmed the devices are useful and are working well.
* Standing agenda items on staff meetings incorporating quality and compliance, including the continuous improvement process and suggestions for improvement.
* Recruitment for several roles including a Director of Care, 3 Clinical managers, and a Quality officer to increase clinical oversight, compliance monitoring, completion of audits, and staff education.
* Refer to Standard 7 for further information on improvement actions in relation to workforce governance.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 8(3)(d)

The service has policies and procedures in relation to the management of high impact and high prevalence risks, abuse and neglect of consumers, supporting consumers to live the best life they can, and incident management and reporting. Staff and management described examples of risks to consumers and how these are managed at the service.

The service demonstrated consumers are supported to take risks of their choosing through discussions between staff and consumers regarding the potential risks, and documentation to support strategies to ensure consumer safety and informed decision-making.

An electronic incident management system is in place, and management and staff demonstrated knowledge of serious incident reporting requirements.

The service was found to be non-compliant in the previous Site audit due to deficits in the service’s risk management processes resulting in risks to consumers not being accurately identified and assessed, and consumers not supported to make informed decisions. The service has implemented the following improvement actions to remediate these deficits, and to strengthen its performance in this Requirement:

* A new risk management framework has been implemented with staff training on the framework provided in January 2023.
* A quarterly ‘lessons learned’ clinical management meeting now occurs to strengthen clinical risk management practices in relation to consumer care.
* Implementation of a new booklet for staff which incorporates information on areas of risk such as serious incident reporting.
* Refer to Requirement 1(3)(d) for information on improvement actions in relation to supporting consumers to live the best life they can.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 8(3)(e)

The service has a clinical governance framework and documented policies in relation to antimicrobial stewardship and minimising the use of restraint. Staff demonstrated knowledge of these policies and described how they apply them as relevant to their roles. Mandatory training documentation evidenced staff have completed training on infection control processes, antimicrobial stewardship, and restrictive practices.

The service was found to be non-compliant in the previous Site audit due to not demonstrating a clinical governance framework in place with policies on antimicrobial stewardship and restrictive practices. The service has implemented the following improvement actions to remediate these deficits, and to strengthen its performance in this Requirement:

* The service has implemented a corporate governance policy and clinical governance framework released to staff in January 2023.
* An antimicrobial stewardship program is in place with supporting policies and procedures. The service has a restrictive practice policy and staff receive training on this.
* A new clinical governance committee has been formed consisting of Clinical managers that meet every 3 months. Three new clinical managers have been recruited to the service responsible for clinical oversight and management.

Based on the information recorded above, it is now my decision this Requirement is 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)