Performance

Report

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| Name of service: | Arcare Glenhaven |
| Service address: | 93 Glenhaven Road Glenhaven NSW 2156 |
| Commission ID: | 1060 |
| Approved provider: | Arcare Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 July 2023 to 14 July 2023 |
| Performance report date: | 18 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 Arcare Glenhaven (**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 13 July to 14 July 2023, 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 4 August 2023
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Directions Notice dated 27 July 2022 following Site Audit conducted 31 May to 2 June 2022, Performance Report dated 12 July 2022 following Site Audit conducted 31 May to 2 June 2022, Site Audit Report following Site Audit conducted 31 May to 2 June 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **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** |

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 1(3)(a) The approved provider must demonstrate that consumers are treated with dignity and respect and their personal care needs are met to maintain their personal presentation and consideration of a change in condition is responded to for consumer’s refusing care.

**Requirement 3(3)(b)** The approved provider must demonstrate that staff are trained and can demonstrate competence in their training to respond to high impact and high prevalence risks and that triggers are identified and mitigation strategies are in place to prevent the incidents from reoccurring.

# Other relevant matters:

The purpose of this Assessment Contact was to assess 4 requirements under the Quality Standards, which were found to be Non-compliant following a Site Audit on 31 May 2022 to 2 June 2022. The Assessment Team was also directed to assess additional requirements: Standard 3 Requirement (3)(b) and Requirement (3)(d). The Assessment Contact commenced at 9:30am on 13 July 2023 and finished at 5pm on 14 July 2023.

# 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. | Non-compliant |

Findings

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

A Site Audit was conducted at the service in May 2022 and following this a regulatory official from the Commission decided that this requirement was Non-compliant. The reasons for the Non-compliance were deficiencies in relation to consumer and representative feedback indicating that staff and services provided have left them feeling undignified, disrespected, embarrassed and scared to speak up due to fear of retribution. The issues highlighted referred to personal care, continence management, call bell response times, cleaning of bathrooms and staff attitude.

The approved provider acknowledged the findings and detailed related actions and planned improvements which included an immediate internal audit of staff training needs and implementation of toolbox talks covering topics such as privacy, dignity and choice. Case conferences with the consumers and families identified as being dissatisfied. Call bell audit to ensure the mobile phones are working and staff are aware of the organisational policy and guidelines in relation to call bell response times.

The Assessment Team found during this Assessment Contact that the service demonstrated overall, most consumers and representatives believe that consumers are treated with dignity and respect. Care plans generally have information that is consistent with the consumer’s identity and culture. Interactions with consumers were observed to be respectful and caring.

The Assessment Team interviewed consumers and representatives who provided feedback that they are treated with respect and the staff are very good and the staff treat them well.

Staff were observed interacting with consumers respectfully and with care. This included sitting with consumers who need assistance with their meals and ensuring they are not rushed with their meal. When speaking to staff about consumers, staff were respectful in how they referred to and spoke about consumers.

However other consumer and representatives did not feel they were respected and treated in a dignified way. One representative expressed significant concerns about the services failure to care for their consumer prior to transfer to hospital. The management team advised that the consumer wishes to undertake personal care without assistance from the service and refuses to be provided with personal care unless it is from family. However, whilst the service recognises the consumer’s rights for self-choice, they have not recognised the consumer’s mental health masking the consumer’s ability to make informed decisions about their care needs. They have not demonstrated their understanding of their duty of care in having systems in place to limit risks. The service has not demonstrated they understand the balance of dignity of risk and duty of care.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement, training records of dignity and risk and escalation of clinical risk, a clinical training session to provide clinicians with a clear understanding of recognising and responding to deterioration and mental health and complaints register feedback including apology for the lack of personal care noted above with actions taken to address the complaint. The approved provider has responded with the provision of training for staff.

I acknowledge the actions that the approved provider has taken, however understand that it will take some time for the staff to demonstrate that the training has been effective.

I find that the approved provider is Non-compliant with this requirement.

# 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 |
| 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 |

Findings

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

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

The Assessment Team interviewed consumers and representatives who provided mixed feedback regarding the management of clinically associated risks to themselves or their family members at the service. The Assessment Team were advised that that pressure injuries, weight loss and falls were the 3 most concerning high impact or high prevalent risks at the service and provided information of how they manage these risks.

The Assessment Team found that the service assesses consumers on admission and completes associated assessments and care plans. Care plan reviews occur 6 monthly or if anything changes, restrictive practice care plans and associated assessments are reviewed 3 monthly or as required. It was observed that consumer assessments and care plans were consistently not reflecting consumers current care needs, goals and preferences. The service advised that they have a large number of assessments and care plans overdue.

The Assessment Team queried the high number of pressure injuries and were advised that that there were multiple contributing factors including consumer frailty, poor nutrition and hydration and consumer dignity of risk and choice. The service spoke about the preventative strategies they implement including doing routine skin checks and providing alternating pressure air mattresses for consumers who are at high risk of developing pressure injuries.

The Assessment Team were advised that the service has an educator from the organisation coming on site to conduct face to face wound prevention and management education. This was evidenced in their quality improvement register. The education will be provided to staff as a result of the delayed identification of wounds or skin break down that has been occurring at the service apart from the recent observation.

The Assessment Team reviewed a consumer who has 3 pressure injuries. The consumer has been reviewed by the clinical wound specialist who recommended a range of strategies The consumer advised that they sometimes get pain from the pressure injuries however has chosen not to accept all the recommendations as per the clinical wound specialist including the air mattress. The representative advised there are issues with the management of pressure injuries and believes the pressure injuries are a result of the consumer being in bed for prolonged periods, making the consumer deconditioned physically as well as developing pressure injuries. A review of the consumer’s documentation showed that the pain care plan was completed 28 September 2021, last reviewed 25 September 2022 and last updated 27 February 2023. The pain assessment and care plan made no mention of pressure injuries. The Assessment Team sighted progress note entries that indicated that the consumer has received as needed pain medication as a result of complaining about the wounds however this was not reflected in the pain assessment or care plan. Management advised they have given the consumer pressure relieving devices, referred the consumer to a wound specialist, liaised with the doctor and had a family conference. They advised they are closely monitoring the wounds however the consumer chooses not to accept the strategies as per the dignity of risk and choice.

The Assessment Team reviewed documentation which showed a number of consumers had weight loss. The service does monthly weights in line with their resident of the day (ROD) process however the clinical risk meetings did identify that not all consumers had their weights completed when they were supposed to. The meeting minutes of 21 June 2023 contained information that 9 Residents of the Day weights were not checked. The service did advise there were certain consumers who chose to not have their weight checked as per their choice and dignity of risk.

The service has work instructions/guidance material for nutrition and hydration. Registered Nurses have accountability of clients’ nutrition and hydration, care plans are to be in place and charting including but not limited to food and fluid records, fluid balance chart, nutritional supplements and weight charts are to be used when required. The work instructions advise the Registered Nurses to specifically monitor - weight loss or gain of 2kg in 1 month, weight loss or gain of 2kg in 3-month period during care plan review. It states to make referrals to doctor, speech pathologist and dietitian where appropriate or necessary. Management advised they are organising training and education for their staff in weight change management.

The Assessment Team identified that there have been 11 falls requiring medical attention in the past 3 months. The Assessment Team were advised that the service follows policies and procedures and have preventative strategies to minimise consumers falling. The service said that falls have increased as a result of consumers not calling for assistance. Other preventative strategies used are bed sensors and beam sensors. Management advised that the electronic care planning system generates work logs after a consumer incident is created to remind staff what actions need to be taken. However, the Assessment Team did note that as per the clinical risk meeting minutes on 21 June 2023, a large number of work log actions were not filled out or completed.

The Assessment Team reviewed documentation for one consumer who has had an extensive falls history over the past 6 months with several behavioural incidents. The consumers pain care plan states that it was published 13 December 2022 and last updated 9 January 2023. The Abbey non-verbal pain assessment conducted shows a score of 4 indicating mild pain. The care plan mentions to monitor the consumer for non-verbal signs of pain, increases or change in behaviours or gait. A review of pain charts between 30 June 2023 to 2 July 2023 show that most pain assessment involved verbal assessing with the responses indicating ‘no pain’. Considering the consumer’s cognition and communication barriers it was not clear why non-verbal pain assessments did not occur as directed by the consumer pain care plan. It is unclear if pain has been a contributing factor for the consumer’s behaviours and pain.

It was evident that the service works closely with consumers, their representatives, other providers of care and services to assist in caring for consumers when incidents occur including when identifying pressure injuries, falls and weight loss however it was not always consistently evident that the service is managing the high impact high prevalent risks of consumers and proactively working to prevent and minimise the impacts of those risks on consumers.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement advising that most of the outstanding assessments and care plans are now up to date, compliance will continue to be monitored in this area. Toolbox training has been conducted on assessment and care planning, pressure injury prevention and management, skin integrity checks, escalation of clinical risks, improving nutritional status and non-verbal pain. Training has also been conducted for SIRS, pain management, falls management and wound prevention and management. All current pressure injuries have been reviewed by the wound consultant and the pressure injury care plans have been checked to reflect the consumers current care needs. Clinical Leads will continue to review pressure injury wound charts weekly to ensure they have been attended to and ongoing training is taking place for all staff with oversight. A review of outstanding worklogs, identified that the team are attending to worklogs but are not closing them off manually, a review was conducted to remove any unnecessary generated worklogs, so that team member can spend more time with consumers instead of completing unnecessary worklogs. The Clinical Lead will become the pain management champion and will be enrolled in additional training courses.

I acknowledge the immediate action that the provider has undertaken, however understand that it will take some time for staff to demonstrate that the training has been effective and can reflect compliance.

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

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

The Assessment Team interviewed consumers and representatives who provided positive feedback in relation to recognition and response related to consumer deterioration. Staff interviewed explained how they support consumers who show signs of deterioration. Management provided information in relation to how the service supports consumers who demonstrate signs of deterioration.

The Assessment Team reviewed documentation for consumers and found that clinical deterioration was responded to quickly and escalated when clinical observations were out of range. The Assessment Team reviewed work instruction documents for ‘acute deterioration of a client's health’ which states ‘when a client's condition changes rapidly or unexpectedly the registered nurse will investigate the cause of the health change, assess the client and continue assessments as long as clinically necessary’. It was evident that this occurred for consumers.

The service demonstrated it responded effectively for a consumer who became involved in incidents and started to show changes in behaviours including physical aggression, by liaising with a geriatrician, the consumer’s doctor, the consumer representative and Dementia Support Australia (DSA) regarding strategies to manage the behaviours including pharmacological and non-pharmacological interventions. A decision was made to transfer the consumer to the high care unit. A review of documentation showed that the consumer was discussed at the last monthly clinical risk meeting. The consumer is on half hourly safety checks and has had medications reviewed. The service states the consumer is settling well in the new area and participates in activities.

The Clinical Lead showed evidence of an email sent to clinical staff reminding them if any changes in client health occurs including deterioration, to please attend a clinical assessment including vital signs check, midstream specimen of urine (MSU), delirium screen and other appropriate assessments and supporting documentation. The email advised to notify doctor, consumer representatives and handover to the following shift Registered Nurse.

The daily systems meetings discuss all consumer incidents over the past 24 hours and other changes to consumers function, condition and capacity to allow the service to respond accordingly.

# 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 Quality Standard has not received a rating as only one of the specific requirements 4(3)(f) has been assessed and found to be Compliant.

A Site Audit was conducted at the service in May 2022 and following this a regulatory official from the Commission decided that this requirement was Non-compliant. The reasons for the Non-compliance were 9 of the 14 consumers interviewed, said they are not satisfied with the meals provided and they said the service has not learnt and acted on the complaints made in relation to the meal service.

The approved provider acknowledged the findings and detailed related actions and planned improvements. This included the review of their kitchen and catering processes and increasing frequency of food focus meeting to weekly for 4 weeks, then fortnightly for 6 weeks, then monthly. The Chef is to meet with consumers who have special dietary requirements, modified diets and visit the dining room after meal service to gather feedback. Room service timing has been reviewed, which limits care staff to 4 meal trays at a time for room service. The seasonal menu was reviewed by dietitian to ensure nutritional requirements are met. A paper-based menu was introduced in the dining room for consumers as well as a digital menu updated and displayed on each dining room screen. Extra choice menu has been added and a fortnightly menu has been set up for selection of plated sandwiches, food safety temperature logs are being reviewed and monitored. Heat lamps have been installed over servery bain-maries, hot box purchased and used to transfer food from kitchen.

The Assessment Team gathered information from an assessment of compliance with the requirement during this Assessment Contact which included interviews with consumers and representatives and found from 12 of 14 consumers and representatives interviewed that they were happy with the meal service, and said, if they were not happy, they could provide this feedback to the management team and they would listen to the consumer feedback and adjust the meal. One consumer said the service hold monthly food focus meetings, where some consumers provide regular feedback to the catering team. The consumer said the meals are varied and tasty and enjoys morning and afternoon tea with cakes or fruit and has a choice of two options for the main meals. If consumer’s do not like those, they can choose to have a salad or a plate of sandwiches. The consumer said the meal service has improved since last year however, the service is finding it difficult to maintain a Chef.

The Assessment Team observed a dining environment that was pleasant and facilitated consumers to connect and socialise. Consumers were assisted with their meals at a pace that suited them.

One representative said they were not happy their consumer was on a minced moist diet and believed the consumer should still be a normal diet, however this has been resolved with more clarity from the speech pathologist. One consumer said they do not like the food at the service and there are times they get hungry however, if the consumer is hungry between meals, they let the staff know, the consumer is always able to get something to eat.

# 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 |

Findings

The Quality Standard has not received a rating as only one of the specific requirements 6(3)(c) has been assessed and found to be Compliant.

A Site Audit was conducted at the service in May 2022 and following this a regulatory official from the Commission decided that this requirement was Non-compliant. The reasons for the Non-compliance were deficiencies in relation to the services ability to effectively resolve the food complaints raised by consumers.

The approved provider acknowledged the findings and detailed related actions and planned improvements. These included a detailed action plan relating to improving the food and meal service. This has been outlined in Standard 4 Requirement (3)(f). Other actions included organising a case conference with all consumers and their families who expressed dissatisfaction with the service’s response to their feedback.

The information gathered from an assessment of Compliance with the requirement during this Assessment Contact demonstrated overall, most consumers and consumer representatives interviewed expressed satisfaction that the service will address and resolve any complaints or issues they raise and staff described how they try and help consumers to resolve their concerns and demonstrated principles of open disclosure.

The complaints and feedback register demonstrates the service is responsive to feedback and has clear timeframes in responding to complaints. Resident meeting minutes and food focus forums indicate the service encourages feedback from consumers and uses this feedback to improve the services provided to consumers.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

The Quality Standard has not received a rating as only one of the specific requirements 7(3)(a) has been assessed and found to be Compliant.

A Site Audit was conducted at the service in May 2022 and following this a regulatory official from the Commission decided that this requirement was Non-compliant. The reasons for the Non-compliance were deficiencies in relation to call bell response times and consumers and representatives interviewed indicated there was not enough staff and provided examples of how this impacted on their personal care, medication management and repositioning when required.

The approved provider acknowledged the findings and detailed related actions and planned improvements. These included the service completing a DECT phone audit, to ensure phones are functioning well and call bells are reflected on the phones. A review of the call bell escalation system to ensure it was functioning, any calls over 5 mins are escalated to the Clinical Lead.

The information gathered from an assessment of Compliance with the requirement during this Assessment Contact found that overall consumers and representatives interviewed were satisfied with the staffing levels at the service. Consumers and representatives said the staff are caring and kind to the consumers living at the service and believe they are well cared for. Interviewed consumers all spoke highly of staff working at the service and said they do not have to wait long to get assistance.

One representative said when visiting their consumer, staff are always on the floor and visible to the consumers. They maybe interacting with the consumers in a room but when she presses the call bell, they are always available.

However two representatives said they do not believe there is sufficient staff on shift within the memory support unit and there is no staff on reception on the weekends. One representative said it was difficult to orientate themselves when the consumer moved from upstairs into the memory support unit on the lower ground floor as there was no one on reception on weekends which made it even more difficult to navigate the service environment. This feedback was provided to the management team who said the café is open on the weekends and the café staff are able to assist with reception duties. If they are not able to, they can call the Registered Nurse who can assist. Two other representatives said there is often no staff to be seen in the memory support unit. This feedback was provided to the management team. They said if they need staff, they just need to press the call bell and the staff will be there.

All care staff interviewed consistently provided feedback that they are able to comfortably complete all their tasks on each shift and believe there is currently sufficient care staff to meet the needs of the consumers. Care staff said management always attempts to fill vacant shifts and replace staff on sick leave.

The Assessment Team observed the 2 levels of the service throughout the Assessment Contact and found staff to be attentive to consumer needs and their safety.

The manager advised the Assessment Team that the service is currently not using agency staff. They have a casual pool of staff they are able to utilise to fill vacant shifts at the service.

If a staff member calls in sick at the last minute the afternoon staff are asked to come in early and they will try to replace the afternoon shift. The Registered Nurse will also complete the medication round and the medication nurse will work on the floor as a care staff to minimise the disruption to care if required.

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)