Performance

Report

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| Name of service: | Carine Parkside Care Community |
| Service address: | 29 Silica Road CARINE WA 6020 |
| Commission ID: | 7466 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 August 2023 |
| Performance report date: | 30 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 Carine Parkside Care Community (**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 consumers, representatives, staff and management;
* an email from the provider received 10 August 2023 accepting the assessment team’s report; and
* a Performance Report dated 10 November 2022 for Site Audit undertaken from 13 September 2022 to 16 September 2022.

# 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 | **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 13 September 2022 to 16 September 2022 as the service did not ensure each consumer was treated with dignity and respect. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including using afloat staff to cover missing shifts; a change in management with more communication with consumers and representatives; and taking appropriate action regarding incidents caused by staff.

At the Assessment Contact undertaken on the 2 August 2023, staff were observed interacting with consumers in a kind and respectful manner. A suite of policies relating to dignity and choice are available to guide staff practice and staff receive training in relation to dignity and respect on an annual basis. Staff from various disciplines said they know consumers well and provide care and services in line with consumers’ cultural needs and preferences. Consumers and representatives interviewed said staff are respectful, use consumers’ preferred names and provide care and services in line with their choice and preferences.

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

**Standard 2**

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |

**Findings**

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 13 September 2022 to 16 September 2022 as the outcomes of assessment and planning were not always available and effectively communicated to the consumer and/or representative. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, implementation of a process where consumers and representatives are involved in the evaluation of the care plan to ensure all parties have input and any changes to care are communicated to the team and the consumer and representatives.

At the Assessment Contact undertaken on the 2 August 2023, effective processes to ensure the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer and where care and services are provided were demonstrated. A care plan tracker ensures all care plans are reviewed and updated every four months, changes are communicated to consumers or representatives, and a copy of the care plan provided. Consumers and representatives interviewed said they had either seen a care plan or care plans had been discussed with them, and were satisfied that the outcomes had been communicated.

For the reasons detailed above, I find requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers 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**

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 13 September 2022 to 16 September 2022 as each consumer was not provided safe and effective personal and/or clinical care which was best practice, tailored to their needs and which optimised their health and well-being, specifically in relation to personal hygiene, toileting, continence care and weight management. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, completed continence assessments for all consumers; provided training to staff on continence management; appointed continence champions; and reviewed behaviour support plans to ensure they are tailored to consumers’ needs.

At the Assessment Contact undertaken on the 2 August 2023, consumers were found to receive safe and effective personal and clinical care, which was best practice, tailored to their needs and optimised their health and well-being. Care files sampled demonstrated consumers receive safe and effective care in relation to personal hygiene, changed behaviours and medication management. Staff described how they tailor care to consumers’ needs and ensure best practice is applied, and consumers and representatives interviewed were satisfied consumers receive safe and effective personal and clinical care.

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

Requirement (3)(f) was found non-compliant following a Site Audit undertaken from 13 September 2022 to 16 September 2022 as consumers’ preferences were not met. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including employed a new head chef, and implemented a new menu with consumer input.

At the Assessment Contact undertaken on the 2 August 2023, consumers expressed satisfaction with the variety, quantity and quality of their meals. One consumer indicated they were enjoying the meals much more since the new head chef commenced and two consumers described meeting with the chef in relation to their preferences. The menu includes the choice of a hot and/or continental breakfast daily and two hot options for lunch and dinner. Salads, sandwiches and other hot options are available as alternatives. Morning, afternoon tea and supper are provided with snacks; and fresh fruit is available. The dining experience was observed to be comfortable and not rushed. There were sufficient staff available to assist consumers, and consumers appeared to be enjoying their meals which were well presented.

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 13 September 2022 to 16 September 2022 as appropriate actions were not always taken in response to complaints or open disclosure consistently used; and feedback and complaints were not reviewed and used 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, undertaking surveys with 10 per cent of all consumers each month; and using feedback from consumers and representatives to improve the dining experience, food and laundry processes.

At the Assessment Contact undertaken on the 2 August 2023, complaints were found to be recorded and appropriate and timely action taken in response. Related documentation sampled demonstrated organisational procedures are followed and appropriate action taken to resolve all complaints. Where the service is not able to reach an agreement acceptable to the consumer and/or their representative, the complaint is escalated to the appropriate person. Staff from various disciplines said they use open disclosure principles in their everyday practice and receive training in open disclosure annually. Consumers and representatives interviewed said when they make a complaint or suggestion, staff respond and resolve any issues in a timely manner. They stated staff and management apologise when things go wrong and check in to ensure any issues they raised are resolved to their satisfaction.

Feedback and complaints were found to be reviewed and used to improve the quality of care and services. Complaints and feedback data is monitored, collated and analysed on a monthly basis, with results discussed at consumer and staff meetings. The data collected is used to identify continuous improvement opportunities. A continuous improvement plan is maintained and demonstrated feedback and complaints data for 2022 had been reviewed resulting in dissatisfaction with food being identified. In response, a range of improvements were initiated, including the appointment of a new head chef, the purchase of hot boxes to keep meals warm, and implementation of food focus groups to discuss improvements to the dining experience. Consumers and representatives interviewed were satisfied their feedback is used to improve care and services.

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)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

Requirements (3)(a) and (3)(e) were found non-compliant following a Site Audit undertaken from 13 September 2022 to 16 September 2022 as the number and mix of staff did not enable safe and quality care and services and monitoring and review processes were not effective; and systems were not effective in identifying deficiencies in assessment, monitoring and review of staff. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including recruitment of care, registered clinical staff, and a head chef; rostered two additional care shifts, one in the morning and one in the afternoon to float between wings; undertaken performance appraisals with all current staff; and created a register to monitor staff appraisal due dates.

At the Assessment Contact undertaken on the 2 August 2023, workforce number and mix was found to be effective in the delivery and management of safe and effective care and services. A standard roster devised by head office is maintained. The roster is flexible, allowing for additional staff to be rostered when consumers’ care needs change. There are processes to manage planned and unplanned leave. Staff interviewed said they generally get their duties completed in time, and they work together if it is busy. Staff said they can speak to their supervisor or management to discuss workload issues, if required. Most consumers and representatives interviewed felt there were generally enough staff on duty to provide and assist with consumers’ care and service needs. However, three consumers and/or representatives indicated call bells were not always answered in a timely manner. They had not formally raised this with staff, and although inconvenient to consumers, none expressed any impact or distress.

Management described how they assess, monitor and review the performance of each staff member and provided examples of staff performance appraisals, and performance management. Management explained processes undertaken where a new staff member was identified as requiring additional support. A plan, including goals and actions, was recorded in collaboration with the staff member, additional support provided, and a review date scheduled. Staff files sampled included a current performance appraisal, and staff interviewed said they have had a performance appraisal discussion with their supervisor, including goal setting for the next 12 months.

For the reasons detailed above, I find requirements (3)(a) 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 |
| 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)(c), (3)(d) and (3)(e) were found non-compliant following a Site Audit undertaken from 13 September 2022 to 16 September 2022 as the service did not demonstrate effective governance systems relating to workforce and feedback and complaints; risks to consumers were continuously monitored and appropriate and timely actions taken if a risk had increased; or an effective framework in relation to open disclosure. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, undertaken a recruitment drive resulting in increased numbers of permanent staff and a reduction on the reliance on agency staff; implemented a new process to ensure all staff understand their responsibilities in relation to risk identification and management; reviewed all restrictive practices and implemented a restrictive practices register; and provided training to staff on restrictive practice and open disclosure.

At the Assessment Contact undertaken on the 2 August 2023, effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were demonstrated. Staff confirmed they have access to information about consumers through the electronic care records, and policies, procedures and step by step guides are accessible to guide practice. A plan for continuous improvement is maintained and opportunities for improvement are identified through a range of avenues, including incident data, audits, feedback and complaints, and changes to legislation. Management described processes for both planned and unplanned expenditures. There are systems to ensure the right number and mix of staff are deployed to enable safe and quality care and services. Rosters and allocations are based on the needs of consumers and changes can be authorised by the service’s general manager, if required, to meet changes in consumer needs. A Serious Incident Response Scheme (SIRS) register is maintained and demonstrated incidents are correctly identified and appropriately reported. There are processes to identify and monitor restrictive practice, and a restrictive practice register is now in place and is monitored and updated. A complaints register sampled demonstrated complaints are actioned in a timely manner, an open disclosure process utilised and follow up with complainant undertaken to ensure satisfaction with the outcome.

Effective risk management and systems relating 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 were demonstrated. A range of processes ensure staff are identifying, managing, escalating, and mitigating risks to consumers. Risks are discussed at daily huddles, weekly team meetings, and reported at both a service and organisational level. Staff described actions they take if abuse or neglect of a consumer is suspected, and processes and supports provided to support consumers to take risks. The incident and SIRS registers demonstrated staff report and escalate issues of concern. Incident reports and incident related documentation included information relating to what happened, investigation to identify root causes, and actions identified and implemented to prevent reoccurrence.

A clinical governance process, inclusive of antimicrobial stewardship, minimising use of restraint and open disclosure, is in place. Data is collected and analysed to inform improvements in clinical care and services, and open disclosure is part of standard practice when negative events occur. Antibiotic usage is monitored and discussed at regular meetings. Discussion with general practitioners has ensured consumers previously prescribed prophylactic antibiotics are no longer receiving these and the use of dip sticks to test for suspected urinary tract infections is no longer promoted. A new restrictive practice register has been implemented and monthly clinical data showed an overall reduction in the use of chemical, mechanical and environmental restrictive practice across the service over the past five months.

For the reasons detailed above, I find requirements (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)