Performance

Report

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| Name of service: | Churches of Christ Golden Age Aged Care Service |
| Service address: | 60 Ridgeway Avenue SOUTHPORT QLD 4215 |
| Commission ID: | 5060 |
| Approved provider: | Churches of Christ in Queensland |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 May 2023 to 10 May 2023 |
| Performance report date: | 15 June 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 Churches of Christ Golden Age Aged Care Service (**the service**) has been prepared by J Earnshaw, 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 31 May 2023
* the performance report dated 15 August 2022 for the site audit conducted 31 May 2022 to 2 June 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 | Non-compliant |
| **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 | **Non-compliant** |
| **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.

* Ensure each consumer is treated with dignity and respect,
* Ensure workforce interactions with consumers are kind, caring and respectful,
* Undertake effective monitoring and review of staff members with identified performance issues

# 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 performance report dated 15 August 2022 found the service non-compliant with requirement 1(3)(a). Deficiencies related to consumers not consistently being treated with respect and dignity in relation to personal care and manual handling.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

* toolbox talks regarding consumer’s dignity and choice and customer service skills.
* conducted Serious incident response scheme and elder abuse training to assist in identifying and recognising instances of inappropriate behaviours and incidents of abuse (completed by 100% of staff at the service).
* training provided to staff related to consumer dignity and respect.

However, the assessment team report provided information that the service was not able to demonstrate consumers are consistently treated with dignity and respect.

Consumer feedback described instances of feeling disrespected and provided examples of staff practices, such as rushing their care delivery and speaking to them in a disrespectful way.

The Assessment Team observed staff treating consumers disrespectfully and not supporting them to maintain their dignity. The assessment team report provided examples of this, including:

* Observation of one named consumer to be left standing without required support, told to wait for further assistance whilst leaving the consumer door open whilst the consumer was in a partially undressed state with lower pants and continence aid. The staff member was observed to return to attend to consumer continence care needs without providing privacy or support to complete the care needs. Management commenced investigation of this incident during the assessment contact.
* The Assessment Team observed a staff member calling out for another staff member to assist them, whilst also not demonstrating awareness of who at the service was staff and able to assist them.
* One named consumer said staff are rough during the provision of care and described how the shower water temperature is often too cold or too hot despite requests for the temperature to be changed.
* One named consumer said staff speak to consumers disrespectfully and said they have been left physically upset.
* Staff were unable to describe practical ways they treat consumers with dignity and respect.

The organisation has a documented Dignity of Care policy and a plan for continuous improvement, with a commitment to a culture of inclusion and respect for consumers.

Management committed to the assessment team, that incidents observed by the Assessment Team will be investigated and responded to and reported if required.

The Approved Provider’s response described actions taken to investigate and address the issues raised by named consumers in the assessment team report. Further advising open disclosure has occurred as a result of said investigations and that a staff member referenced is no longer employed by the service.

These actions included consumer experience surveys, notification to staff to emphasise the importance of respecting consumer’s privacy and dignity, respectful communication when providing care to consumers, face-to-face toolbox training on mindfulness, dignity and respect, and the industry Code of Conduct of the expectation of how to care for and communicate in the living environment of consumers.

Consumers and representatives stated consumers are not consistently treated with dignity and respect. The Assessment Team report described observations of consumers not being treated respectfully and with dignity by staff. I have considered these matters further under requirements 7(3)(b) and 7(3)(e).

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response which included a plan for continuous improvement. I acknowledge that the plan for continuous improvement and response describes the measures taken by the service to address the deficiencies identified, however, I am not satisfied that these actions have been effective. Therefore, I find this Requirement is non-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 performance report dated 15 August 2022 found the service non-compliant in requirement 2(3)(a). Deficiencies related to care planning documentation did not consistently identify or document risk assessments and the service was unable to demonstrate involvement of consumers and representatives in care planning review.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

* Implementation of a schedule of review and staff allocation to review consumer care planning documentation.
* Registered staff orientation includes training in relation to care plan assessment and review.
* A clinical support consultant was employed in December 2022 to provide support and clinical monitoring of the service.
* Twice weekly clinical meetings held to discuss clinical matters.
* Implementation of a Registered Nurse in charge role to support the clinical care coordinator for improved oversight of wound management and monitoring and completion of care plan reviews.

The service demonstrated assessment and care planning included consideration of risks to consumers’ health and well-being and addressed the management of pain, falls, and skin integrity care in care and service delivery. Care and services were reviewed regularly for effectiveness and when circumstances changed, or incidents occurred.

Consumers and representatives provided positive feedback and reported assessment and care planning process delivered safe and effective personal care and services.

Care planning documentation demonstrated consumers’ needs and preferences had been identified and assessed, referrals to allied health specialists occurred and strategies to minimise risk to consumers were documented.

I am satisfied that the service has addressed the deficiencies previously identified and I am satisfied that this Requirement is compliant through the implementation of these actions.

# 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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The performance report dated 15 August 2022 found the service non-compliant in requirement 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e) and 3(3)(f).

Deficiencies related to not being able to demonstrate effective personal and clinical care and consumer dissatisfaction related to recognition of and response to changes to consumers’ health conditions, consumer needs and preferences not consistently shared across the service. And consumers were not satisfied that timely and appropriate referrals occur.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements.

The service has implemented a number of interventions to ensure clinical deterioration is recognised and responded to including increased clinical support, staff training and after-hours support.

Consumers and representatives considered consumers received personal care and clinical care that is safe, right for them and in accordance with the consumers’ individual needs and preferences.

Consumers and representatives expressed satisfaction that consumers’ needs, and preferences were effectively communicated between staff.

Care planning documentation for consumers demonstrated effective assessment, management and evaluation of restrictive practices, falls, skin integrity and pain.

Where restrictive practices are in place, assessments, informed consent from consumers and/or representatives and monitoring were demonstrated. Behaviour support plans are in place for consumers who are subject to restrictive practices. Review of documentation confirms consumers’ medication is reviewed regularly by the Medical Officer.

The service was able to demonstrate consumers experiencing chronic pain receive regular pain assessments and validated assessment tools are used, with both pharmacological and non-pharmacological interventions included in care planning documentation, with pain relief medication reviewed for effectiveness.

Consumers with pressure injuries and other wound types have a wound care plan, with regular measuring, photographing and referral to specialist wound services as required.

Whilst the assessment team report brought forward information that the service was unable to demonstrate effective processes to manage high-impact or high-prevalence risks associated with the care of each consumer. I am satisfied by the Approved Provider’s response detailing remedial actions implemented, and that care documentation identified consumers at risk. Staff were able to describe risks to the consumers including falls, skin integrity, and pain management and the risk mitigation strategies that are used for these.

Staff were able to describe and care documentation confirmed, the ways they recognise and respond to deterioration or change in the consumer’s condition.

The Assessment Team report described the ways in which information was shared amongst staff, which included within the electronic care management system, handover and staff meetings.

Consumers and their representatives said the service recognises and responds to changes in a suitable and timely manner. Appropriate referrals are made to other healthcare providers and organizations. Care planning documentation evidenced input and directives from other health professionals.

In coming to my decision for requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e) and 3(3)(f), I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response which included a plan for continuous improvement and evidence of implementation of actions taken.

Therefore, I am satisfied that the service has addressed the deficiencies identified under these requirements, and I am satisfied that these Requirements are compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The performance report dated 15 August 2022 found the service non-compliant in requirement 4(3)(d). Deficiencies related to Consumers’ needs and preferences were not adequately communicated.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

* Implementation of a schedule of review and staff allocation to review consumer care planning documentation with clinical oversight.
* Inclusion of changes of consumer needs, preferences or condition is communicated at handover and updated in the electronic care records.

The service was able to demonstrate that information about consumers’ needs and preferences are shared with all care providers involved in consumer care provision within the service.

Consumers said staff are delivering individual care in the ways they have communicated and feel their preferences are known.

Staff demonstrated knowledge of individual consumer preferences and described how information is accessed and shared amongst staff.

Care planning and other documentation demonstrated consumers’ preferences and needs related to meals and personal care.

I am satisfied that the service has addressed the deficiencies previously identified and I am satisfied that this Requirement is compliant through the implementation of these actions.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The performance report dated 15 August 2022 found the service non-compliant under requirement 6(3)(a) and 6(3)(d). Deficiencies related to consumers and representatives were not consistently aware of how to provide feedback and/or lodge complaints; and a lack of documentation to demonstrate feedback and complaints were reviewed and used to improve quality of care and services.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions include:

* The service has implemented an electronic complaints management system documenting complaints received verbally, via feedback forms and feedback received through consumer meetings and internal audits. This system is monitored at an organisational level.
* Discussion of feedback and complaints at consumer meetings and staff meetings.
* The service has documented timeframes to resolve and close complaints and any complaints outside of this timeframe are escalated to the regional manager and clinical governance team through alerts in the electronic system.
* The service trends and analyses complaints on a monthly basis.
* The service has completed code of conduct and dignity and respect training.
* The complaints management system demonstrated complaints are recorded, followed up and actions have been taken.

The service demonstrated a complaints management system with documented actions and improvements.

Consumers and representatives said they are encouraged and supported to provide feedback. and described satisfactory resolutions to complaints raised.

Staff demonstrated an understanding of the complaints process and how to assist consumers to make complaints.

Management advised how they encourage consumers and representatives to make complaints through feedback forms, consumer meetings and internal audits.

The plan for continuous improvement evidenced information related to complaints was documented and included improvements implemented and subsequent actions taken to remediate the concerns raised.

Some consumers and representatives described improvements to services related to feedback provided.

Staff provided examples of how feedback has influenced improvements to quality care and services. Management was able to demonstrate feedback is reviewed and has been used to make changes to care and services. For example:

* The service has implemented ongoing measures to ensure meals are delivered at acceptable temperatures.
* As requested by consumers, the service has created a station in the dining room for consumers to prepare tea and coffee any time they wish to.
* Some consumers said they had made complaints regarding not being treated respectfully by staff. These complaints were documented, and the service demonstrated actions were taken to improve staff interactions with consumers through additional training and discussions at staff meetings. However, some consumers reported ongoing issues. I have considered this further under Requirement’s 1(3)(a), 7(3)(b) and 7(3)(e).

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response. I am satisfied that the remedial actions implemented by the service has addressed the deficiencies identified therefore, I am satisfied that these Requirements are 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)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Non-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. | Non-compliant |

Findings

The performance report dated 15 August 2022 found the service non-compliant under requirements 7(3)(a), 7(3)(b), 7(3)(d) and 7(3)(e).

In relation to requirements 7(3)(a) and 7(3)(d), deficiencies related to delays to the delivery of care, staff not feeling supported to provide adequate care to consumers; Consumers reporting staff were not adequately trained and not all mandatory training had been completed by staff at the time of the Site Audit.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

* Rostering care and registered staff from multiple sites to help fill the service’s roster.
* Engaged additional contract staff agencies.
* Employment of a clinical support consultant to provide clinical guidance, assist in the evaluation of clinical performance.
* Implementation of a Registered Nurse in charge role to support the clinical care coordinator for improved oversight of wound management and monitoring and completion of care plan reviews.
* Implementation of a part-time quality nurse position to oversee operations and performance of the service.
* Ongoing recruitment of clinical and care staff and partnerships with local tertiary education centres.
* Roster changes to ensure a clinical manager is on call 24 hours per day and 7 days per week.
* Conducted call bell responsiveness training and toolbox talks to staff around timely cares.
* Provided manual handling training for new equipment and appointed 4 manual handling ‘champions’ to provide ongoing training for staff.
* Engaged with the local hospital to undertake palliation and deterioration training for selected clinical staff.
* Appointed a senior care staff member to monitor and weekly review of staff training compliance.

The service demonstrated the workforce is planned to meet the needs of consumers and the service has systems and processes in place to ensure there is sufficient staff rostered across all shifts. Call bell response times were monitored, with delays in response for assistance investigated by management.

The service was able to demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Consumers and representatives consider they received quality care and services when they need them from people who were knowledgeable and capable.

Staff considered there were sufficient staff, and the right mix of staff, to plan and deliver care and services in accordance with the consumers’ needs and preferences.

Management described how they determine whether staff are competent and capable in their role, which included induction on commencement of employment, and completion of mandatory training programs.

Management described how the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards. Systems and processes were in place to identify general training needs and provide education to staff.

I am satisfied the workforce is planned to deliver safe, quality care and services and is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Therefore, I am satisfied that Requirements 7(3)(a) and 7(3)(d) are compliant through the implementation of these actions.

In relation to requirements 7(3)(b) and 7(3)(e), deficiencies related to observation of disrespectful treatment of consumers by staff and staff performance appraisals being overdue.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

* Implementing toolbox talks, discussions at handovers, and staff training in relation to treating consumers with respect. Management advised the assessment team that this training is mandatory, however, the service only evidenced 16 of 100 staff members have completed this training and staff advised they were not aware this training is mandatory.
* added code of conduct to staff meeting agenda, however, staff meeting minutes did not provide any detail of the discussion.

Plan for continuous improvement updated to include:

* quarterly face-to-face mandatory training on team culture.
* Investigations into the incidents observed by the Assessment Team of staff not demonstrating respectful behaviour towards consumers.
* Mandate further code of conduct training for all staff members.
* Appointment of administration staff to centrally monitor and book performance appraisals for all staff.
* further training to the service manager around staff performance management.
* further training for registered staff on key focus areas such as leadership training, performance management and escalation advice.

However, these actions have not been effective as the Assessment Team observed and consumers provided feedback of instances of staff treating consumers in a disrespectful manner.

Staff did not demonstrate understanding of respectful or kind interactions with consumers and one staff member reported knowingly not reporting unkind treatment of a consumer. Consumers described examples of disrespectful and rough treatment by staff. One named consumer became emotional regarding a complaint of staff misconduct.

Whilst the service was able to demonstrate that they have addressed the deficiency related to staff performance appraisals, the service was unable to demonstrate effective monitoring and review of staff members when performance issues are raised.

Serious incident reporting of the service identified three separate incidents reported of use of unreasonable force and neglect, related to three consumers by one staff member. However, the service was unable to demonstrate adequate documented investigation or measures taken in response to these allegations. Further of note, the staff member involved did not have current performance appraisals or documented performance management actions. The Service, did however, in response to the assessment team’s feedback, commenced investigation into these incidents and stood down the staff member pending the outcome of said investigation.

The Approved provider, in their response, described planned actions to address the identified deficits and advised individual investigations had commenced into the performance of two staff members identified with recurring allegations in serious reportable incidents. Further advising, these staff members are no longer employed at the Service.

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response. I acknowledge that the response describes the measures taken and planned by the service to address the deficiencies identified, however, I am not satisfied that these actions have been sufficiently implemented or evaluated for effectiveness. Therefore, I find requirements 7(3)(b) and 7(3)(e), non-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 |

Findings

The performance report dated 15 August 2022 found the service non-compliant in requirement 8(3)(c). Deficiencies related to ineffective governance systems relating to information management, continuous improvement and workforce governance.

The assessment contact conducted 8 May to 10 May 2023 found the service had taken action to improve performance under these requirements. Actions included:

The organisation has improved oversight of complaints, continuous improvement and workforce through improved accountabilities and processes, and created electronic dashboards that are dynamically updated. The service’s plan of continuous improvement is updated and reviewed regularly to include actions and improvements related to complaints, incidents and clinical indicators. The service has systems in place for monitoring and tracking staff training and performance appraisals.

The service was able to demonstrate effective governance systems were in place to ensure accountability and oversight.

Consumers and representatives were satisfied with the information provided to them and said that consumers received care and services that met their needs and preferences. The service has ongoing recruitment processes in place and has introduced additional roles including senior clinical staff, registered nurses, and care staff.

The service has an electronic care management system and staff demonstrated knowledge on accessing and maintaining consumer information.

Management demonstrated how opportunities for continuous improvement are identified through consumer feedback, incidents, audit results and clinical incident data. Consumers provided examples of improvements implemented at the service as a result of feedback.

The service demonstrated systems are in place to monitor workforce competency and ensure the workforce is appropriately planned to facilitate the delivery of safe and effective consumer care. However, the service was unable to demonstrate effective performance management of staff. I have considered this under Requirement 7(3)(e).

The service demonstrated systems are in place to encourage the provision of consumer feedback and complaints and ensure appropriate and proportionate action is taken. Evidence of open disclosure was observed within staff practices and how consumer feedback and complaints positively contribute to improvement initiatives and outcomes.

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response which included a plan for continuous improvement.

I am satisfied that the service has addressed the deficiencies identified under this requirement, therefore I am satisfied that this Requirement is 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)