Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Churches of Christ Gracehaven Aged Care Service |
| Service address: | 71 Dr Mays Road BUNDABERG QLD 4670 |
| Commission ID: | 5245 |
| Approved provider: | Churches of Christ in Queensland |
| Activity type: | Assessment Contact - Site |
| Activity date: | 20 March 2023 to 22 March 2023 |
| Performance report date: | 3 May 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 Gracehaven Aged Care Service (**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 17 April 2023 providing additional information.
* the site audit report for the site audit conducted 29 March 2022 to 31 March 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | 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 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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 6(3)(d) – Ensure feedback and complaints are consistently documented, reviewed, and used to improve the quality of care and services.
* Requirement 7(3)(d) – Ensure staff understand and apply the knowledge gained through training and implement effective systems and practices to monitor and ensure ongoing training compliance.
* Requirement 8(3)(c) – Ensure an effective organisation-wide governance system relating to workforce governance, regulatory compliance and feedback and complaints.
* Requirement 8(3)(d) – Implement effective risk management systems and practices to identify and respond to abuse of consumers, and to manage and prevent incidents.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to consumers not being consistently treated with dignity and respect. The service took action to address and remediate deficits leading to the Non-compliance.

The service was ensuring consumers were treated with dignity and respect, and documenting information regarding consumers’ identity, culture and personal preferences to guide staff when providing care and services. Consumers expressed satisfaction with their treatment by staff. Staff demonstrated a shared understanding of treating consumers with dignity and respect and had awareness of each consumer’s identity. Staff confirmed the service was the home of the consumers and were able to demonstrate an inclusive culture and an understanding of consumers’ choice and independence. Care documentation identified consumers’ lifestyle preferences and personal stories to guide staff in meaningful interactions.

Staff were observed treating consumers with dignity and respect throughout the site visit. Staff were observed knocking on consumers’ room doors and identifying themselves before entering and providing consumers with assistance during mealtimes in a calm and respectful manner.

Management implemented the topic of treating consumers with dignity and respect as a standing agenda item at all staff meetings, in addition to related education sessions on Positive Wellbeing. Signed attendance sheets were provided which confirm 100% of staff attended a staff meeting or toolbox education session.

Management distributed the Code of Conduct policy requiring all staff to sign their acknowledgement of the Code of Conduct and return this to management. Management met with consumers and representatives identified as complainants in the previous Site audit report and the complainants were provided with apologies. Management surveyed all consumers and representatives, and results of the survey demonstrated all consumers and representatives were satisfied with the actions taken to ensure consumers were treated with dignity and respect, and the ongoing education of staff.

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

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to restrictive practices not being implemented in line with legislative requirements, and unplanned weight loss not being managed in accordance with the service’s policy and procedure. The service took action to address and remediate deficits leading to the Non-compliance.

Consumers and representatives provided positive feedback that consumers who were subject to a restrictive practice were receiving care that was right for them and optimised their health and well-being, and that the restrictive practice was used as a last resort. The service’s restrictive practice register confirmed consumers subject to a restrictive practice were listed and identified the type of restrictive practice, dates of the signed consents and authorities, review dates of the restrictive practice in line with the organisation's policy and that behavioural support plans were in place.

The service maintained a psychotropic medication register which reflected all consumers prescribed a psychotropic medication. Management reviewed all consumers prescribed a psychotropic medication and those who were, or may be, subject to all forms of restrictive practices. Where there were deficiencies in documentation, management arranged for the Medical officer and authorised representative to review and complete outstanding documentation. Review of the register confirmed those consumers not subject to chemical restrictive practice had a corresponding diagnosis to support the use of the psychotropic medication. Review of the high-risk high prevalence data analysis report confirms a reduction in the use of chemical, mechanical, and environmental restrictive practice at the service from December 2022 to February 2023.

Restrictive practice compliance was included in the service’s Plan for continuous improvement which included actions such as a survey developed to gain an understanding of staff’s knowledge of restrictive practice which guided the development of training. Management received restrictive practice education from a clinical support consultant. Restrictive practice education was provided to registered and care staff with 100% participation as evidenced by attendance records. Registered and care staff demonstrated a shared understanding of restrictive practices, including the difference between mechanical and physical restrictive practice. Restrictive practice was included as a permanent agenda item in monthly staff meetings as evidenced in staff meeting minutes.

Unplanned weight loss was added to the service’s Plan for continuous improvement which included the Care Manager and Clinical care co-ordinator monitoring consumers’ weights monthly and referring consumers to the Medical officer and dietitian if weight loss occurred. Unplanned weight loss was included on the high-risk high prevalence report for monitoring, trending, and analysis.

Care planning documentation was reviewed for consumers requiring management of unplanned weight loss. This demonstrated, and consumer and staff interviews confirmed, consumers were receiving individualised care which was safe and right for them and was based on best practice. All consumers were weighed on entry to the service, monthly or if there was a change in the consumer’s condition and when they returned from hospital. If weight loss was identified, the consumer was referred to the dietitian and Medical officer and immediately commenced on a food and fluid chart pending review from the dietitian or Medical officer.

Review of staff meeting minutes confirmed unplanned weight loss was included as a standing agenda item at staff meetings including the process of escalation as per the service’s policy. Education records evidence 100% staff attended education sessions for completion of food and fluid charts following the previous Site audit.

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

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |

Findings

Requirement 6(3)(c)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to not consistently taking appropriate and timely action and applying an open disclosure process in response to complaints.

The service was unable to demonstrate that appropriate action is taken in response to all consumer and representative feedback and complaints. While the service’s complaints register contained 3 complaints, interviews and documentation review did not support all complaints had been recorded or actioned.

For one named consumer, episodes of verbal abuse sustained from another consumer were not recorded despite clinical staff being aware of the abuse. Staff confirmed while they were aware of the incidents occurring, they had not recorded the incidents and the verbal abuse continues to occur. Following feedback, management sought to record and escalate the incident and a referral has occurred to support the complainant.

Meeting minutes contained complaints from 4 consumers which were not recorded in the service’s complaints register, and therefore rectification actions were not taken. Feedback was also provided by 4 consumers and a representative that their concerns relating to a consumer who calls out, were not recorded or actioned.

Management acknowledged deficiencies in documenting all complaints and responding to them in an appropriate and timely manner. Management did not provide plans to improve the complaints management process at the time of the Assessment Contact.

The Approved Provider in its written response to the Assessment contact – Site report included documentation evidencing actions taken to respond to and resolve complaints raised by consumers identified under the report. The Approved Provider submitted an incident report documenting actions taken by the service to address the complaint of one consumer regarding verbal abuse from another consumer. Progress notes and feedback forms completed by 4 consumers who had raised complaints regarding the consumer who calls out were provided. Review of documentation demonstrates individual case conferences were held with all 4 consumers, an open disclosure process was applied, and action taken to resolve the matter to the satisfaction of the consumers.

The Approved Provider’s response states regional management have reviewed how meetings are conducted at the service and implemented a new process whereby the Service manager is to chair every consumer meeting. This process improvement has been implemented to ensure feedback and complaints are consistently documented and responded to in line with the service’s complaints management protocol. Staff have been enrolled in feedback and complaints refresher training.

Based on the information recorded above, I am satisfied the Approved Provider has resolved the complaints raised by individual consumers and applied an open disclosure process. It is now my decision this Requirement is Compliant.

Requirement 6(3)(d)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to not consistently reviewing feedback and complaints and using these to make improvements. The service was unable to demonstrate that all feedback and complaints were recorded, reviewed, and used to improve the quality of care and services. Through interviews and document review, the Assessment Team identified a number of complaints that were not recorded in the service’s complaints and feedback register and were not used to improve the quality of care and services.

For one named consumer subjected to verbal abuse, this abuse was not recorded, actioned or addressed, continues to occur and therefore not improving the quality of care for the consumer. Feedback from consumers relating to a consumer who consistently calls out disturbing the sleep of consumers and another consumer who swears has not been recorded and no action has been taken to improve the quality of care for the consumers. The service’s Plan for continuous improvement did not contain actions relating to complaints or feedback.

The Approved Provider’s response states all complaints identified under the service’s consumer meeting minutes have now been recorded in the service’ electronic complaints management system. Actions have been taken to resolve the complaints of consumers identified in the Assessment contact – Site report, to their satisfaction as outlined under Requirement 6(3)(c).

A memo was circulated to all staff as a reminder to report all feedback and complaints received by consumers, representatives, and other visitors at the service. Regional management have reviewed how meetings are conducted at the service and implemented a new process whereby the Service manager is to chair every consumer meeting. This process improvement is to ensure feedback and complaints are consistently documented and responded to in line with the service’s complaints management protocol. The service’s Care Manager has been mentored to ensure continuous improvement opportunities are identified and documented, and the service’s administration officer has been provided training on how to record meeting minutes correctly.

No information was provided regarding how the service plans to ensure improvement actions arising out of feedback and complaints submitted via all avenues are consistently documented under the service’s plan for continuous improvement, or to demonstrate this is currently occurring.

As identified above, the service has taken immediate action to address the deficits identified in the Assessment contact – Site report. I acknowledge the commitment of the Approved Provider; however, I am of the view these 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

|  |  |  |
| --- | --- | --- |
| 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to having insufficient staff to deliver timely care and services that aligned with consumers’ preferences and care and services plans. The service took action to address and remediate deficits leading to the Non-compliance.

The service was able to demonstrate there was sufficient staff to deliver timely care and services. Consumers and representatives provided positive feedback in relation to the sufficiency and timeliness of staff to assist in delivering consumer care needs. Staff across various roles confirmed they had sufficient time to undertake their allocated roles and responsibilities, and to provide care and services in line with consumer preferences and needs. Management described the processes for managing unexpected leave and conducted monthly audits to ensure the workforce was planned to enable the delivery and management of safe and quality care and services. Audit results indicated the base roster was suitable to deliver care and services that aligned with the consumers’ preferences and needs.

Monthly rostering audits were conducted, and incidents were reviewed to determine if the workforce was planned to deliver safe and quality care and services. In February 2023, the service identified an increase in the number of consumers with behaviours of concern and introduced a four-hour shift in the afternoon to provide one on one assistance for those consumers and an extra care staff shift between 2:00pm and 8:00pm to provide additional support. Clinical management conducted observations during morning and afternoon tea to monitor and ensure that safe and effective care was being provided.

Based on the information recorded above and the satisfaction levels of consumers and representatives regarding the timeliness of staff assistance, it is my decision this Requirement is now Compliant.

Requirement 7(3)(b)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to consumers not being consistently treated with kindness and respect. The service took action to address and remediate deficits leading to the Non-compliance.

Most consumers and representatives confirmed consumers were treated with kindness, and staff were caring and respectful of consumers’ identity, culture and diversity. Staff interactions were observed to be kind, caring and respectful. Staff demonstrated an understanding of consumers’ identity, culture, needs and preferences to whom they provided care and services. This information aligned with care planning documentation and the information obtained by way of interviews with consumers and representatives.

Daily observations of staff performance were conducted by management. Incidents and feedback including instances where staff had not been kind, caring or respectful were investigated. For one staff member, this resulted in performance management actions, as a result of investigation findings.

Staff meetings included a standing agenda item reminding staff to be kind, caring and respectful, and a memorandum was sent to remind staff of the service’s behavioural expectations.

Based on the information recorded above and the satisfaction levels of consumers and representatives regarding the kindness and respectfulness of staff, it is my decision this Requirement is now Compliant.

Requirement 7(3)(d)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to ineffective processes to monitor mandatory training completion, and training to address deficiencies in staff performance not being delivered in a timely or effective manner.

While consumers provided feedback stating they felt staff were well trained and provide quality services as a result, the service was unable to demonstrate effective processes to monitor and ensure the completion of mandatory training. Deficits in staff knowledge was evidenced by the inconsistent recording of complaints and identification and reporting of serious incidents. This has been evidenced in Non-compliance in Requirements 6(3)(c), 6 (3)(d) and 8(3)(c).

Mandatory training audits did not identify deficits in training or staff knowledge. Reporting processes to demonstrate staff had completed mandatory training were ineffective and the service used a separate training matrix to monitor training completion. The service’s training matrix identified up to 57% of staff had not completed one component of mandatory training.

Management confirmed the organisation made the decision to remove training in relation to the Quality Standards, Elder abuse, Neglect and Harm from the mandatory training modules and staff can complete this training as part of their personal development. Whilst management advised all staff completed this training prior to the removal from mandatory training requirements, this was unable to be evidenced at the Assessment contact, and deficits in incident recording and reporting have occurred.

The Approved Provider’s response includes documentary evidence demonstrating all staff were sent reminders via bulk text message and memos to complete mandatory training following the site visit. A training report extracted from the service’s electronic learning system identifies staff have achieved compliance with mandatory training modules, including on the Serious Incident Response Scheme. A register has been established to record staff attendance at toolbox education sessions.

The Approved Provider states the service has developed a compliance dashboard to address software limitations in compliance reporting. The dashboard is currently in its pilot phase and is intended to better enable monitoring of training compliance by providing management across the organisation with continuous access to live data via the electronic learning system.

Whilst I acknowledge the Approved Provider’s efforts to ensure staff are up to date with mandatory training; sufficient time and testing is required to demonstrate training has been effective in improving deficits in staff practice, particularly reporting and recording of serious incidents and feedback and complaints as evidenced in Requirements 6(3)(c), 6(3)(d) and 8(3)(c). Improvements to the service’s processes and systems for monitoring training compliance need to be tested to ensure their effectiveness and sustainability. Therefore, it is my decision this Requirement is Non-compliant.

Requirement 7(3)(e)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to staff performance not being regularly assessed, monitored or reviewed. The service took action to address and remediate deficits leading to the Non-compliance.

The service demonstrated staff participated in a performance review in the last 12 months. Staff collaborated with their supervisor to identify gaps in their skills and knowledge and develop strategies to address the gaps. Most consumers were satisfied with the performance of staff, and this was evidenced in survey results.

Daily observations of staff performance were undertaken by management. Feedback and complaints were reviewed to identify instances where staff practices were involved. Examples of performance management activities undertaken in response to identified deficiencies in staff performance were provided.

Consumer and staff meeting minutes included a standing agenda item to encourage consumers and staff to report staff performance that did not align with the service’s code of conduct, policies, or procedures. Staff confirmed this was a standing agenda item, and they felt encouraged to report staff performance that did not align with the service’s code of conduct. Management provided investigation, performance management, and disciplinary documentation for 4 staff members who, in the last 12 months, had been identified as acting in a way that did not align with the service’s code of conduct.

In deciding this Requirement is Compliant, I have considered the processes the service had in place to monitor staff and identify poor staff performance. While I have considered staff have not received effective training and support to identify, record and report serious incidents, I have considered the weight of that information in Requirement 7(3)(c). Therefore, it is my decision this Requirement is now Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | Non-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. | Non-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

Requirement 8(3)(c)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to ineffective governance systems relating to workforce governance, regulatory compliance and feedback and complaints. The service was not able to demonstrate improvement actions to address deficits have been effective.

In relation to workforce governance and regulatory compliance, staff did not demonstrate the knowledge and skills to identify, record, report and escalate episodes of serious incidents in line with regulatory obligations. For one named consumer subjected to verbal abuse, despite staff awareness of the abuse, incidents were not recorded to allow for the investigation of the incidents and the consumer sustained further abuse.

Pertaining to feedback and complaints, complaints were not consistently recorded and therefore were not actioned in a timely manner or appropriately.

The Approved Provider in its response included information as outlined under Requirements 6(3)(c), 6(3)(d) and 7(3)(d) above to return the service to compliance in relation to feedback and complaints and workforce governance. The service remains Non-complaint in Requirements 6(3)(d) and 7(3)(d).

In relation to regulatory compliance, the Approved Provider advised the incident of verbal abuse brought to the attention of management during the Assessment contact has now been reported, staff have completed mandatory training on the Serious Incident Response Scheme, and review of serious incidents that have occurred at the service in the past 6 months has identified these have been appropriately investigated.

Based on the information recorded above, I am of the view improvements implemented at the service will need time to demonstrate their effectiveness and sustainability. Therefore, it is my decision this Requirement remains Non-compliant.

Requirement 8(3)(d)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 in relation to identifying and responding to the abuse and neglect of consumers and managing and preventing incidents.

The service’s risk management systems were not effective in identifying and responding to abuse of a consumer. For one named consumer who was subjected to verbal abuse, incidents had not been recorded or escalated as per regulatory requirements. Staff had failed to identify the incidents as serious and remedial actions had not been taken to prevent reoccurrence of the abuse.

While the service had policies and procedures relating to the reporting of serious incidents, this did not occur for one named consumer and monitoring mechanisms failed to identify a serious incident had occurred but had not been reported.

The Approved Provider’s response includes documentary evidence to demonstrate all staff have undertaken mandatory training in the Serious Incident Response Scheme and have access to work instructions on how to identify and report serious incidents. The Service manager was provided mentoring on serious incident reporting requirements and has completed additional online education on the Serious Incident Response Scheme. In response to complaints of verbal aggression identified under the Assessment contact, incident reports were submitted, and investigation occurred.

Based on the information recorded above, I am of the view actions taken by the service will need time to demonstrate their effectiveness and sustainability in ensuring the recognition, reporting and escalation of serious incidents. Therefore, it is my decision this Requirement remains Non-compliant.

Requirement 8(3)(e)

The service was found to be Non-compliant in this Requirement at the Site audit conducted 29-31 March 2022 as the service had an ineffective clinical governance framework in relation to recognising consumers subject to restrictive practices, consumers who had experienced unplanned weight loss, and the process of using open disclosure when things went wrong.

The service’s restrictive practice register evidenced all consumers subject to a restrictive practice were identified and included the type of restrictive practice, dates of the authorisation and consent by the Medical officer and consumer or substitute decision maker, and when the restrictive practice was due for review. Review of care planning documentation for consumers evidenced unplanned weight loss is managed in line with the service’s policy and procedures.

The organisation implemented a documented clinical governance framework and policies in relation to restrictive practices and open disclosure. The Care manager was responsible for the oversight of the application of the clinical governance framework with additional monitoring and oversight provided by the Service manager and the organisation’s quality compliance team.

Management described the open disclosure process at the service which was used in dealing with complaints and incidents that occurred and were able to provide examples of how open disclosure had been utilised. Staff were aware of open disclosure and when it was used following a complaint or when things went wrong.

Actions taken by the service to rectify deficits in this Requirement included auditing of the service’s restrictive practice and psychotropic medication register. Monthly trending, analysis and monitoring of restrictive practice was occurring. Education was provided for management by the Regional clinical support team to ensure their knowledge was current to effectively perform their roles.

Based on the information recorded above, it is my decision an effective clinical governance framework is in place and therefore this Requirement is now 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)