Performance

Report

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| 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: | 8 August 2023 |
| Performance report date: | 22 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 Churches of Christ Gracehaven Aged Care Service (**the service**) has been prepared by K. Reed, 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 performance report completed 03 May 2023, following the Assessment Contact – Site 20-22 March 2023
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| 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 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives were encouraged and supported to give feedback and make complaints and were satisfied with actions taken by the service in response to concerns raised. Open disclosure was applied, where required, and feedback from consumers and representatives was used to continuously improve care and services.

The service trended and analysed complaints, feedback and concerns raised by consumers and representatives and used this information to inform continuous improvement activities across the service which were documented under the service’s Plan for continuous improvement.

Staff assisted consumers when competing feedback and complaint forms if they required assistance. Feedback forms and boxes were placed in several areas around the service and completed forms collected by the Service manager.

The service has taken actions to address previous non-compliance identified at the Assessment contact conducted 20-22 March 2023.

The electronic complaints and feedback system was not used to its full potential previously but now staff have received training and instruction on how to effectively use, record, collate and monitor complaints and feedback.

The service established an action in their electronically monitored Plan for continuous improvement to ensure complaints and feedback were reviewed and improvements were documented. The service trended feedback and complaints from consumers to identify areas for improvement, the results of trending were presented at various staff meetings, which was evidenced in meeting minutes.

Consumers and representatives were provided ongoing opportunity to provide feedback and provided updates regarding the progress of continuous improvement actions, this was evidenced through monthly consumer meeting minutes.

Various policies and procedures were updated including the Feedback, complaints, and appeals policy was reviewed and updated 13 June 2023.

The Plan for continuous improvement was audited monthly to ensure improvements had occurred.

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

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Consumers and representatives were satisfied staff were trained to provide safe and effective care to consumers. Staff considered they were appropriately trained, supported, and equipped to perform their roles. Management monitored staff compliance with mandatory training through the electronic care management system and provided staff with support shifts, additional training when the need was identified.

All new staff complete an orientation program during induction and are required to complete all mandatory training modules within three days of commencement with refresher training provided annually. Management and staff confirmed, staff who had not completed their mandatory training were stood down until training was completed.

Staff received reminders to complete training through their internal electronic systems and notifications to their personal phones at 90 days and 30 days prior to completion deadlines. Staff received a full training calendar with dates and times of training in advance and can be reviewed through their internal electronic training system. Staff described the training, support, professional development, and supervision they received during orientation and on an ongoing basis. Management and staff confirmed additional training was provided where requested or identified during performance development processes.

The service has taken actions to address previous non-compliance identified at the Assessment contact conducted 20-22 March 2023.

The service established an action in their Plan for continuous improvement to ensure staff completed mandatory training and implemented a monitoring process to ensure staff compliance with all mandatory and ongoing training. A new dedicated staff member was tasked to monitor completion of all training including mandatory training and competency testing included in the training.

A training compliance report identified 100 per cent of all staff have completed mandatory training modules with the exception of five staff who were completing their outstanding training at the time of the Assessment contact. Training records demonstrated ongoing training was provided to staff by subject matter experts on topics including, but not limited to incident management, Serious incident response scheme, confidentiality and privacy, feedback and complaints and infection control.

Agency staff were no longer used, all rostered shifts were currently filled by permanent or part-time or casual staff. Staff were paid for seven hours training to complete all of their online mandatory training modules. Two Clinical nurses and a Care manager continually monitored competency in regard to any training.

All new staff received a minimum of two supported buddy shifts but could have more if requested or required. All staff must complete 44 training modules within two days of commencement. Toolbox talks have been provided to all clinical staff on a wide range of topics.

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

Findings

Requirement 8(3)(c)

The service demonstrated governance systems were in place and the systems were monitored and reviewed to ensure the best outcomes for consumers. The organisation had a clinical governance team and Regional manager who provided oversight and accountability to the service. The Service manager described how the governance systems operated and their role in overseeing and monitoring governance systems.

Opportunities for continuous improvement were identified through consumer feedback, incidents, audit results and clinical incident data. Clinical staff and consumer meeting minutes for June and July 2023 recorded discussions of ongoing improvements related to complaints or as a result of increases in clinical incidents.

The process for monitoring and ensuring staff training was current and in date included reviewing compliance rates on a monthly basis. The clinical governance team oversaw staff training compliance rates and escalated to the Service manager if staff training was not current.

The organisation monitored new and changed legislation through subscriptions and disseminated these changes to the service. Changes were communicated through email to staff. A review of incidents and the service’s serious incident reporting demonstrated compliance with the legislative requirements relating to the Serious incident response scheme.

The complaints management system ensured complaints were documented, reviewed and actions were completed. Management reported and discussed complaints with the clinical governance team and were accountable to demonstrate appropriate actions had been completed. The service’s complaints register demonstrated a system for capturing feedback and complaints and a review process.

The service has taken actions to address previous non-compliance identified at the Assessment contact conducted 20-22 March 2023.

The service implemented improved monitoring of systems for staff training, complaints and feedback and regulatory compliance to ensure the systems were maintained. Management completed training in the Serious incident response scheme provided by the organisation’s clinical governance team and the Commission to identify reporting requirements for the scheme. Staff have completed training for incident management and the Serious incident response scheme. All staff demonstrated an understanding of the service’s systems for monitoring training, complaints, and incident reporting. Training records included staff completion of incident management and the Serious incident response scheme.

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

**Requirement 8(3)(d)**

The service demonstrated practices which supported the management of incidents. Staff demonstrated understanding of the Serious incident response scheme and reporting and escalation requirements for incidents. The incident management system alerted the management team when an incident had been documented and they monitored the progress to ensure effective investigation, follow up and closure. Any incidents which met the reporting requirements for the Serious incident response scheme were identified in this meeting if not previously escalated by staff. Registered staff advised how incidents were documented in the incident management system. Clinical nurses reviewed incidents to ensure they were documented appropriately and completed investigations to determine any actions taken to mitigate further risk.

The service has taken actions to address previous non-compliance identified at the Assessment contact conducted 20-22 March 2023.

The management team and staff have completed incident and Serious incident response scheme training, training records documented the completed training. Incident reports for the last three months demonstrated the service identified any incidents which met the reporting criteria for the scheme. The management team met daily to discuss incidents and ensured appropriate follow up and identification of incidents requiring reporting. Staff and consumer meeting minutes for June and July 2023 recorded discussions relating to incidents. Monthly reports detailed incidents, analysis and trending were provided to the organisation’s clinical governance team.

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