Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Estia Health Figtree |
| Commission ID: | 2684 |
| Address: | 12 Suttor Place, FIGTREE, New South Wales, 2525 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 18 October 2023 to 19 October 2023 |
| Performance report date: | 30 November 2023 |
| Service included in this assessment: | Provider: 5951 Estia Investments Pty Ltd  Service: 1041 Estia Health Figtree |

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 Estia Health Figtree (**the service**) has been prepared by Therese Solomon, 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 (performance assessment) – 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 21 November 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not applicable as not all requirements assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements 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

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

Service documentation reviewed confirmed a consumer diversity framework and policy are in place at the service. Some consumers confirmed they felt respected, and their identity, culture and diversity were valued at all times. Staff discussed consumer’s individual histories, culture, preferences and needs. A review of care documentation for consumers demonstrated detailed and accurate information regarding consumer life histories, identities, culture and diversity is collected and included in care planning. This information matched verbal information obtained from consumer and/or representatives.

The Assessment Team identified some deficits through a review of serious incident records, and discussions with management about serious incidents, which showed that staff have not consistently treated consumers with dignity and respect. Although the identified incidents have been dealt with, feedback during the Assessment Contact from consumers and/or representatives and additional observations by the Assessment Team demonstrate the service is not consistently treating consumers with dignity and respect.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 1(3)(a) is found 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

Documentation review and consumer and staff feedback indicate the service is managing skin integrity and pressure injuries safely and effectively. However, the Assessment Team received mixed feedback from consumers and/or representatives in relation to personal hygiene needs and preferences being met by the service. Deficiencies were identified in the areas of medication management, including chemical restraint and behaviour support, and in the management of unplanned weight loss.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found Compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 4(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Mixed feedback was received in relation to meals, however most consumers and/or representatives provided positive feedback and were satisfied with the meals at the service. The chef advised how the service manages and monitors consumer preferences and choice. Observations made support that varied, and quality meals are provided to consumers.

The chef advised the Assessment Team of processes in place for the communication of dietary needs of consumers, and that consumers have the opportunity to provide feedback either verbally or on feedback forms.

# Standard 6

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

Findings

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Management described the process in place for receiving and responding to feedback and complaints. They described the continuous improvement process related to complaints and provided examples of changes occurring within the service in response to feedback. This process aligned with the current feedback policy, complaints and open disclosure and the service’s continuous improvement framework policy.

Staff described the complaints process and how this feedback linked into a continuous improvement process. Review of documentation, including the feedback and complaints register and the plan for continuous improvement, confirmed improvements were being implemented as a result of feedback. Consumers and/or representatives confirmed they were aware of complaints processes in place and were confident of management’s ability to respond and resolve issues and make changes if required.

# 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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Management outlined workforce planning for the service. This included reviewing the roster, extending rostered shifts, and adding additional shifts when required, recruiting and onboarding staff to fill vacant shifts and reducing reliance on temporary personnel. Most rostered shifts are being filled and there is daily monitoring and follow-up of call bell response times in discussion with the affected consumers.

Consumers and/or representatives and staff members provided mixed feedback in relation to staffing, stating that there is not enough staff to meet consumer needs and preferences. The service demonstrated the workforce is planned to enable the delivery and management of safe and quality care and services, however the Assessment Team identified areas for improvement within the current deployed workforce.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 7(3)(a) is found Compliant.

Management described the staff competency framework and stated they assesses whether staff are competent and capable in their role through consumer, representative and staff feedback; observing staff practice and talking with staff; staff performance appraisals; and review of data such as the quality indicators and incident reports. Mandatory skills assessments relating to manual handling, hand hygiene and donning and doffing personal protective equipment are required for all staff to complete.

Staff confirmed the availability of training related to their role and stated they are advised of new training that is available each month. Staff stated they attend training and have their skills assessed and provided examples of training which they found useful. However, the Assessment Team identified some areas for improvement within training and competency related to new employees and registered nurses.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 7(3)(c) is found 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. | 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) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated effective governance systems are in place to ensure the delivery of safe and effective care and services.

In relation to continuous improvement, and feedback and complaints, the manager described the process of how information is relayed to the governing body concerning consumer feedback and complaints. This includes, but is not limited to, complaints escalated to the Commission, serious incidents, and other significant complaints along with information about how they are being managed and related improvements. Documentation was provided and reviewed confirming this occurs.

In relation to continuous improvement and workforce governance, the regional manager explained there are organisation-wide staff recruitment projects underway, such as international recruitment efforts to ensure an adequate workforce is available to facility to delivery of care and services.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has a documented risk management framework, which provides guidance in relation to risk identification, assessment, management, monitoring and review. The regional manager explained how the governing body directs and oversees risk management across the organisation, including the outcomes from monthly reviews of strategic risk and effectiveness of the risk controls. The regional manager shared documentation confirming this.

There are organisational policies and procedures in place providing management and staff with guidance in relation to the managing high impact high prevalence risks, responding to abuse of consumers, supporting consumers to live their best life, and managing and preventing incidents. The regional manager outlined the data and information which is reported on regularly to the governing body; and the Assessment Team reviewed documentation confirming this.

Documentation demonstrated analysis, trending and internal benchmarking about consumer high-impact and high-prevalence care risks, incidents, and feedback and complaints. The manager explained the data and information feeds into ongoing risk assessment and results in service-level risk ratings, and this helps identify services across the organisation where improvement is needed and results in more central support being provided and increased monitoring.

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)