Performance

Report

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| Name: | Georges Estate Health & Aged Care |
| Commission ID: | 1112 |
| Address: | 1 Centre Street, Penshurst, New South Wales, 2222 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 11 July 2024 to 12 July 2024 |
| Performance report date: | 3 September 2024 |
| Service included in this assessment: | Provider: 6804 Kogarah Health, Aged and Community Care (NSW) Pty Ltd  Service: 5868 Georges Estate Health & Aged Care |

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 Georges Estate Health & Aged Care (**the service**) has been prepared by Katrina Platt, 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 on 6 August 2024.

# Assessment summary

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| Standard 4 Services and supports for daily living | Not Applicable |
| **Standard 6** Feedback and complaints | **Not Applicable** |

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 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement 4(3)(f) was Not Compliant following a Site Audit conducted from 8 November 2023 to 10 November 2023. An Assessment Contact was conducted from 11 July 2024 to 12 July 2024 to reassess the Requirement.

Most consumers described some improvements in meal service quality, however, were required at times to choose meals several days in advance. Consumer meal preferences and dietician recommendations were not always provided and some foods were served too often, even when this feedback was provided. Staff were not always knowledgeable about consumer dietary needs and preferences, communication processes for review of consumer meals or dietary requirements and correct fluid preparation. Consumer care documentation lacked staff guidance on safe meal support measures and consumer food and fluid charts were not always completed.

In response to the Assessment Team report, the approved provider referenced the plan for continuous improvement, the various new process and improvement trials being conducted and the recent rollout of a new food and nutrition system, which is fully integrated with the current electronic care management system. This new system integration ensures consumer choices, preferences, and dietary and nutritional needs are easily accessible to all staff at all times.

The approved provider discussed that consumer preferences for menu selections are being honoured and alternate meal options are available at mealtime if required. The winter menu has undergone further revision and feedback from the food focus meetings has been incorporated. Results from the food survey managed by Flinders University are pending. Supporting documentation including progress notes and dignity of risk assessments were provided to demonstrate appropriate action is taken to manage consumer diet-related preferences and associated risks.

Staff have completed consumer dining experience training and have received further education to ensure they are familiar with consumer dietary requirements. Staff training on correct clinical documentation has been provided and regular audits have been introduced to ensure ongoing capability is demonstrated. The leadership team continues to provide additional support to staff during mealtimes and seek feedback from consumers about their dining experiences.

In making a decision on Requirement 4(3)(f), I have considered the intent of the Requirement and the commitment demonstrated by the approved provider to improving the nutrition, hydration and dining experience of consumers. I am satisfied the improvement measures undertaken have been effective and I am confident the approved provider’s actions support their ongoing practice of continuous improvement. I therefore, find Requirement 4(3)(f) is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement 6(3)(c) was Not Compliant following a Site Audit conducted from 8 November 2023 to 10 November 2023. An Assessment Contact was conducted from 11 July 2024 to 12 July 2024 to reassess the Requirement.

Consumers described delayed apologies to complaints made and closure before appropriate consultation was undertaken. The complaints register captured multiple areas of feedback and complaints and some actions were considered ineffective. Management discussed actions taken for complaints management which included education and training, performance management and direct staff communication.

In response to the Assessment Team report, the approved provider discussed the new feedback register which incorporates actions, communication, open disclosure and evaluation processes. The plan for continuous improvement submitted for consideration identified a comprehensive complaints management education program has been delivered to the majority of staff and actions are in place to ensure all staff receive this training.

The approved provider noted an additional process of documenting the complaint has been incorporated into the electronic care management system to ensure the consumer is fully engaged in the complaint resolution process and feedback entries will remain open until satisfaction is expressed by the consumer. A review of the feedback register was noted in the plan for continuous improvement to ensure all complaints were resolved to the satisfaction of consumers and to ensure processes relating to complaints management were undertaken.

Supporting documentation submitted by the approved provider demonstrates ongoing engagement with staff and education and training about the importance of communication and evidence of clinical staff meetings where various topics relating to complaint and incident management were incorporated for discussion.

In making a decision on Requirement 6(3)(c), I have considered the intent of the Requirement which requires a best practice system to manage feedback and complaints, an open disclosure process and a culture where people feel supported and encouraged to report negative events. I am satisfied the approved provider has demonstrated appropriate systems and processes are in place and continuous improvement has been ongoing and is effective. I therefore find Requirement 6(3)(c) 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)