Performance

Report

**1800 951 822**

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| Name of service: | Jeta Gardens Aged Care Facility |
| Service address: | 27 Clarendon Avenue BETHANIA QLD 4205 |
| Commission ID: | 5554 |
| Approved provider: | Jeta Gardens Aged Care (Qld) Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 31 October 2022 to 1 November 2022 |
| Performance report date: | 24 November 2022 |

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 Jeta Gardens Aged Care Facility (**the service**) has been prepared by G. Cain, 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 23 November 2022, after a 3-day extension was granted to the provider.
* the following information given to the Commission, or to the assessment team for the Assessment Contact - Site of the service:
  + The Assessment Team interviewed 7 consumers and/or representatives during the Assessment Contact – Site, who were satisfied with the care and services received.
* other information and intelligence held by the Commission regarding the service.

# Assessment summary

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| 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.

* The organisation is required to ensure staff are trained and equipped to deliver outcomes required by the standards.
* The organisation is required to ensure regular assessment, monitoring, and review of the performance of each member of the workforce.
* The organisation is required to ensure that effective organisation wide governance systems are in place including in relation to workforce governance.

# 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. | Non-compliant |

Findings

The performance report dated 21 May 2022 found the service non-compliant in requirement 7(3)(d). Deficiencies related to lack of staff training in restrictive practices, serious incident reporting and the Aged Care Quality Standards; and effective systems and processes to track, monitor and ensure the delivery of orientation for new staff, including agency staff.

The Assessment Team report provided information which identified consumers/representatives expressed satisfaction with the delivery of their care and services, feel safe and feel staff are well equipped to perform their roles.

While the Assessment Team report evidenced the service has taken action to improve its performance under this requirement, for example through staffs’ completion of mandatory online training modules, and processes to ensure appropriate authorisations for restrictive practices; the service was unable to evidence the sustainability of these actions. Staff were unable to demonstrate a shared understanding of restrictive practices, the Serious Incident Response Scheme, and the Aged Care Quality Standards. For example; when prompted, some staff were unable to provide examples as to what is considered a restrictive practice, including the service’s process to ensure appropriate authorisations are in place; and what would be reportable under the Serious Incident Response Scheme.

The approved provider in its response to the Assessment Team report acknowledges that improvements are required under requirement 7(3)(d); including development and training for the workforce in restrictive practices and the Serious Incident Response Scheme. The approved provider committed to further training for staff including, but not limited to, restrictive practices, the Serious Incident Response Scheme, and the Aged Care Quality Standards with a plan for this to be completed in December 2022.

While I acknowledge the immediate and planned actions undertaken and committed to by the Approved Provider since the Assessment Contact, I am of the view improvements will require time to be implemented and evaluated for effectiveness. For the reasons detailed, it is my decision that this requirement is Non-Compliant.

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| Human resources | |  |
| 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 21 May 2022 found the service non-compliant in requirement 7(3)(e). Deficiencies related to lack of evidence that the workforce had regular assessment, monitoring and review of the performance of each member of the workforce.

The Assessment Team report discloses that this requirement was assessed by interviews with management, staff and review of documentation.

While the Assessment Team report evidenced the service has taken action to improve its performance under this requirement, for example the implementation of a performance management procedure and processes for performance reviews at established timeframes, however, the service was unable to evidence the sustainability of these actions. Management and staff confirmed staffs’ performance reviews were overdue, and review of documentation identified 49% of probationary performances reviews and 32% of annual performance reviews were overdue.

In coming to my decision for this requirement, I have considered the approved provider’s response which acknowledges that improvements are required under requirement 7(3)(e). The approved providered has committed to 100% of probationary reviews, and 95% of annual performance reviews to be completed prior to 31 December 2022. I acknowledge the actions taken to improve compliance under this requirement, and the planned actions committed to by the Approved Provider since the Assessment Contact. I am of the view improvements will require time to be implemented and evaluated for effectiveness, and for the reasons detailed, it is my decision that this requirement is 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. | Non-compliant |

Findings

The performance report dated 21 May 2022 found the service non-compliant in requirement 8(3)(c). Deficiencies related to lack of evidence of effective organisational governance systems related to continuous improvement, workforce governance and regulatory compliance.

The Assessment Team report discloses that this requirement was assessed by interviews with management, staff and review of documentation.

With respect to continuous improvement, the Assessment Team report evidenced the service has taken action to improve its performance under this requirement, including the implementation of key performance indicators for reporting and monitoring of clinical incidents; and the review and development of a clinical governance framework and outbreak management plan.

With respect of workforce governance, the Assessment Team report evidenced the service has taken action to improve its performance, including the engagement of an external human resources consultancy group to refine the organisations systems and processes. The approved provider in their response acknowledged recruitment of key service positions including a human resources manager has been difficult. The Assessment Team report evidence feedback form staff in relation to not being provided position descriptions or being expected to undertake duties beyond their position description. As part of their response, the approved provider asserted the service has issued staff with position descriptions and duties lists for roles and responsibilities at induction, as part of change processes and via training. However, I am unable to come to a view in relation to this as the approved providers response did not descend into the detail through documents supplied as part of the response. I note the approved providers response included information that a review of all position descriptions to ensure core accountabilities are clear is currently being undertaken by the external human resources consultants engaged by the service.

The approved provider acknowledges that improvements are still required, and provided an action plan with key improvement actions including:

* + The development of a strategic workforce plan
  + Contract management, including review of all position descriptions with clear accountabilities
  + Development of a workforce training matrix, including an employee training and development lifecycle
  + Leadership development including managing and measuring performance

With respect of regulatory compliance, the Assessment Team report raised issues in relation to the service not demonstrating compliance with legislative requirements, specifically in relation to the authorisation and consent for chemical restrictive practice. The Assessment Team report provided information that the service did not consider any consumers as subject to chemical restrict practices; 2 named consumers. were restrictive practices authorisations and consents had not been reviewed within the last 6 months, and that the service’s restrictive practice procedure did not include the requirement of a behaviour support plan for consumers subject to restrictive practices.

As part of their response, the approved provider provided information in response to the issues raised in the Assessment Team report, including:

* The organisation’s restrictive practices procedure, which outlines the requirements for chemical restrictive practice including the requirement of the prescriber to rationale the prescribing of medications in line with the Quality of Care Principles 2014. Additionally, in relation to the requirement for behaviour support plans, a copy of the organisations Management of Responsive Behaviours procedure was provided which evidence this requirement for consumers.
* For the 2 named consumers in the Assessment Team report, the approved provided confirmed these consumers were subject to environmental restrictive practice due to residing in the services secure living environment. Information evidenced, authorisations and consents for restrictive practices had been completed and verbal consent had been confirmed from the consumers representative.

In relation to regulatory compliance, I have considered information provided in the Assessment Team report evidencing processes to ensure compliance with legislation including subscriptions to peak body’s; and review of the service’s incident documentation identified incidents falling within the scope of the Serious Incident Response Scheme have been appropriated reported in line with legislated timeframes. I am satisfied the organisation does have systems and processes to ensure regulatory compliance.

In coming to my decision under this requirement, I have considered the Assessment Team report and the approve providers response acknowledging the deficits in workforce governance and the explanation of the actions to be taken to return to compliance. I am of the view improvements will require time to be implemented and evaluated for effectiveness. For the reasons detailed, it is my decision that this requirement is Non-Compliant.

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| Organisational governance | |  |
| 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

The performance report dated 21 May 2022 found the service non-compliant in requirement 8(3)(d). Deficiencies related to lack of evidence of the sustainability, monitoring and effectiveness of newly established risk management systems and practices.

The organisation’s demonstrated the implementation and effectiveness of risk management systems to identify, manage and monitor high-impact, high-prevalence risks associated with the care of consumers including falls, skin integrity, pressure injuries and medication incidents. The organisation had policies describing how to manage high impact and high prevalence risks; respond to abuse and neglect; support consumer choice and decision-making; and report and manage incidents. Management and staff were aware of these policies and able to describe what they meant for them in a practical way.

The Assessment Team report provided evidence that the service has taken action to improve its performance under this requirement including:

* implemented and effective Serious Incident Response policy and process; and risk management system.
* mechanisms to ensure appropriate identification, monitoring and reporting of incidents by staff and demonstrated that this is occurring through review of the service’s incident register, Serious Incident Response reporting and consumer progress notes.

For the reasons detailed, it is my decision that this requirement is Compliant.

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| Organisational governance | |  |
| 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

The performance report dated 21 May 2022 found the service non-compliant in requirement 8(3)(e).

Deficiencies related to implementation of the service’s clinical governance framework, including evidence of established internal monitoring and lack of shared understanding in relation to the clinical governance framework.

The Site Audit report provided evidence that the service has taken action to improve its performance under this requirement including:

* Introduction of a clinical governance frame work in April 2022, which included the establishment of a clinical governance committee. Review of the service’s clinical governance committee meeting minutes identified clinical indicators, audits and training were reviewed and discussed, and a clinical governance report is tabled at monthly governing board meetings.
* The framework supports daily communication in relation to consumers’ clinical and personal care needs, and education has been provided to clinical and care staff.
* Management and staff described the clinical governance framework and shared an understanding of related policies, and their application to their role.
* Staff have been trained in the clinical governance framework and demonstrated a shared understanding of associated policies and how these are applied in their role.

I have considered information presented under this and other requirements assessed, I am satisfied that the service has a clinical governance framework with identified responsibilities, and systems and processes to ensure the delivery of safe, quality clinical care for consumers. For the reasons detailed, it is my decision that this requirement is Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)