Performance

Report

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| Name of service: | Newstead Grand Care Community |
| Service address: | Level 3 & 4, 50 Longland Street NEWSTEAD QLD 4006 |
| Commission ID: | 5758 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 May 2023 to 24 May 2023 |
| Performance report date: | 22 June 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 Newstead Grand Care Community (**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 site audit report for the site audit conducted 19 April 2022 to 21 April 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **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 3

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| 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 has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 19-21 April 2022.

The service demonstrated safe and effective provision of personal and clinical care including management of skin integrity, pain, changed behaviours, restrictive practices, and continence care. Consumers and representatives expressed satisfaction with the delivery of personal and clinical care at the service. Care planning documentation identified information to guide staff in the delivery of care in line with consumers’ individual needs and to optimise their health and wellbeing. Staff were aware of individual consumers’ needs and strategies in place to support their care. Clinical policies and procedures are available to guide staff practice.

The service maintains a psychotropic register capturing information regarding consumers’ diagnosis, type of medication, and strategies used prior to the implementation of a chemical restraint. For consumers subject to restrictive practices, review of documentation evidenced appropriate assessments, authorisations, consent, behaviour support plans, and monitoring in place.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate each consumer was receiving safe and effective personal care tailored to their needs in relation to hygiene preferences and showering. The service has implemented the following improvement actions to remediate these deficits:

* Consumers’ individual preferences and care needs were reviewed, and personal hygiene care plans developed in line with the organisation’s policy. Review of care documentation and personal hygiene care plans demonstrated information such as consumers’ preferences for male or female carers, preferred day, and time they wish to have a shower or sponge bath, and dressing requirements are documented. Care documentation is reviewed 4 monthly with schedules in place to remind staff to re-assess. Consumers reported they receive showers and cares as per their preferred time.
* A personal hygiene preference list has been created and placed in each residential area to remind staff of consumers’ preferences and to ensure these are carried out each day. Preference lists corresponded to information under care documentation for sampled consumers.
* All staff have received education and training on the service’s electronic care management system and how to document consumer preferences. Interviews with staff and review of training records confirmed this has occurred.
* The service monitors its performance of care and service delivery through feedback and complaints mechanisms including via monthly consumer meetings, with service management providing a weekly report to the organisation’s Regional general manager. Review of consumer meeting minutes identified positive feedback from consumers on the care and services they receive.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service has taken action to remediate deficits leading to the non-compliance in the below Requirements as identified under the Site audit conducted 19-21 April 2022.

Requirement 4(3)(a)

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate consumers receives safe and effective services and supports for daily living specifically with regard to laundry services not being consistent and consumers often losing items of personal laundry.

Consumers and representatives confirmed they receive services and supports for daily living in line with their expectations, the laundry service is reliable, and their clothes are returned in a timely manner. Management advised the service is moving from outsourcing laundry services to having this managed in-house. Laundry staff confirmed the service has been transitioning to an in-house laundry system and have found it to be a seamless process.

The service has implemented the following improvement actions to remediate deficits:

* The service has commenced new processes to ensure identification of each item of consumers’ clothing on admission, labelling of new clothing items, and lost laundry items retrieval. Staff and consumers were aware of these new processes and confirmed they occur.
* The service is ensuring laundry staffing levels are adequate by including an additional shift with two laundry staff available during weekdays and one staff member available on a Saturday. Laundry staff confirmed this staffing level is sufficient to cater to the needs of consumers. Management advised additional staffing will be considered as required.
* Workflow laundry management processes have been introduced to guide staff. Staff confirmed these processes have been implemented and are effective.
* A new dryer and washing machine have been installed to cater to the increased needs of consumers.
* Information about the new laundry processes is included under the consumer information pack and newsletters. Review of the information pack and newsletters identified this information is included.
* The new laundry service processes are monitored through feedback and complaints mechanisms, consumer meetings, and surveys. Review of consumer meeting minutes identified positive feedback regarding laundry services.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 4(3)(f)

Consumers and representatives said consumers enjoy the meals, the meals are served at the right temperature, are of good quality and quantity, and they are provided with alternative meal choices if they wish. Staff were able to describe how they access information regarding each consumer’s dietary needs and preferences and how they ensure meal temperatures are monitored. Consumers have the opportunity to provide feedback regarding meals via different avenues. Service management review and discuss any feedback and complaints with the service’s Chef and address these as part of regular food focus meetings. The assessment team observed consumers being offered meal choices and alternatives and receiving requested meals during breakfast and lunch service during the assessment contact.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate that meals were varied, of suitable quality, quantity, and temperature. The service has implemented the following improvement actions to remediate deficits:

* Provision of training and guidance to catering staff to ensure meals are of the correct temperature and consumers are receiving meals of appropriate quantity and quality. Catering staff confirmed they have received training.
* The organisation’s Regional hospitality consultant has attended the service on several occasions to support catering staff and developed a workflow for staff to follow which includes a temperature monitoring process. Review of documentation identified temperatures are recorded by catering staff for all meals and are monitored by the service’s Chef.
* The organisation has purchased additional equipment including but not limited to bain-maries, hot boxes, heat lamps, induction plates, and food delivery trolleys with heat retaining covers to ensure meals are served at the correct temperatures. The assessment team observed staff using this equipment.
* The service ensures ongoing monitoring of consumer feedback on meals via monthly consumer and food focus meetings and food experience surveys. Review of recent meeting minutes and surveys identified positive feedback and high satisfaction ratings in relation to meals.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service has taken action to address and remediate deficits leading to the non-compliance in the below Requirements as identified under the Site audit conducted 19-21 April 2022.

Requirement 6(3)(c)

Consumers and representatives are satisfied appropriate action is taken in response to complaints in a timely manner. All complaints are documented in the service’s electronic feedback system, reviewed by management, and an open disclosure process applied in response. Staff and management demonstrated a shared understanding of processes to follow when a complaint is received. Review of complaints records identified complaints are actioned in a timely manner. Policies and procedures on feedback and complaints management and open disclosure are available to guide staff practice.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate that action is taken to respond to feedback and complaints in a timely manner and an open disclosure process is used when things go wrong. The service has implemented the following improvement actions to remediate deficits:

* All feedback and complaints management processes at the service were reviewed to identify opportunities for improvement. An action plan was developed and completed with education and support of service management on complaints management processes; documentation of all feedback, complaints and suggestions via the service’s electronic complaints management system linked to the service’s continuous improvement plan; and discussion of complaints at daily clinical staff huddles, handover, and staff meetings.
* The service has reviewed all previous complaints to ensure these had been appropriately actioned and resolved. Review of complaints records confirmed this.
* The service now documents consumer feedback and actions taken in response to concerns raised in consumer meetings. Review of consumer meeting minutes evidenced this occurs.
* The service now discusses feedback and complaints at monthly quality meetings, which include monitoring of all complaints from consumers/representatives through the service’s balanced scorecard. This information is reviewed in conjunction with the service’s continuous improvement plan and communicated to staff, consumers/representatives and at the organisational level to the Board. Review of quality meeting minutes confirmed this occurs.
* The service has implemented various monitoring mechanisms to ensure feedback and complaints mechanisms are effective. These include 3 monthly consumer experience surveys; daily walkarounds by the clinical manager to receive and respond to consumer feedback; and oversight of the electronic complaints register and continuous improvement plan by service management to ensure items are only closed following consultation with management and consumer/representative satisfaction.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 6(3)(d)

Consumers and representatives said the service takes action in response to their feedback and provided examples such as improvements to the service’s meals. Management advised the service trends and analyses feedback and complaints to inform continuous improvement activities across the service. All complaints are investigated by service management and where appropriate, the service’s processes are reviewed and areas for improvement identified. All feedback and complaints are entered into the service’s electronic system supported by the balanced scorecard which informs the service’s continuous improvement plan. Review of documentation identified complaints are regularly reviewed and trended to ensure any trends lead to improvement action. Review of the service’s continuous improvement plan identified various improvements to care and service delivery in response to feedback.

The service was found to be non-compliant in the previous Site audit due to being unable to demonstrate complaints and feedback were consistently recorded, reviewed, and used to improve care and services. The service has implemented the following improvement actions to remediate deficits:

* The service monitors feedback and complaints regularly through analysis of surveys and review of consumer meeting minutes to ensure complaints are entered into the electronic system and linked to the continuous improvement plan where required.
* The service’s continuous improvement plan is audited monthly at the quality meeting. Actions items can only be closed by the Regional general manager and not at the service level to ensure appropriate oversight and to confirm actions have been completed.
* The service conducted a series of consumer surveys including a 3-monthly consumer feedback survey and monthly food satisfaction survey in response to complaints trends. Survey results evidenced most consumers and representatives felt feedback was actioned and had resulted in improvements.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

# Standard 7

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

Findings

The service has taken action to remediate deficits leading to the non-compliance in the below Requirements as identified under the Site audit conducted 19-21 April 2022.

Requirement 7(3)(a)

Consumers and representatives said they are satisfied the service has enough staff to deliver care that meets consumers’ needs and preferences and did not express concerns regarding having to wait for care in accordance with their preferred times. Staff reported there are sufficient staff rostered, they have enough time to complete their allocated tasks, and generally staff on leave are replaced. Review of documentation such as complaints records and consumer meeting minutes evidenced consumer and representative satisfaction with staffing numbers. The assessment team observed staff responding to call bells in a timely manner during the assessment contact visit.

The service was found to be non-compliant in the previous Site audit due to consumers expressing concerns about the timeliness of care provided and having to compromise their preferred care options to accommodate workforce levels. The service has implemented the following improvement actions to remediate deficits:

* Management advised a review of the roster was undertaken and additional staff have been recruited, including 3 registered nurses and 23 care staff. A review of rosters evidenced additional morning and afternoon care shifts.
* Management advised, and staff confirmed, staff on sick leave are replaced. Review of documentation evidenced this occurs.
* Call bell response times greater than 3 minutes are analysed by management to identify the cause and call bell data is discussed at daily huddle meetings of clinical and care staff. Review of call bell reports identified majority calls are responded to within 3 minutes with 98% calls being responded to under 10 minutes as per April 2023 call bell reports.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 7(3)(d)

Consumers and representatives expressed satisfaction with the competence of staff and said staff know what they are doing. The service implements a training program for all staff which includes orientation, mandatory training, and role-specific training. Staff said they were satisfied with the service’s training program.

The service was found to be non-compliant in the previous Site audit due to not providing evidence that staff undertake mandatory training. The service has implemented the following improvement actions to remediate deficits:

* The completion of an orientation program is mandatory for all staff. Staff confirmed they receive orientation on commencement with the service.
* A new electronic training platform has been implemented to deliver staff training. Staff confirmed they know how to access this training system and records evidenced all staff have completed mandatory training. Training is provided on a range of topics including but not limited to infection control, manual handling, fire safety, serious incident response scheme, and the aged care quality standards.
* The service has appointed a Clinical nurse educator to onboard new staff and to monitor mandatory training completion. The nurse educator uses a training matrix to record completed training. Management monitor training completion with processes in place to ensure staff complete outstanding training.
* Staff are informed of upcoming training and provided reminders via staff meetings. A list of planned training was observed on display at the service.

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

Requirement 7(3)(e)

The service has a program to regularly assess staff performance which includes a probationary appraisal at 6 months and annually thereafter. Staff confirmed they have participated in appraisals at the service and were aware of upcoming appraisals. Consumers and representatives said they were satisfied with the performance of staff.

The service was found to be non-compliant in the previous Site audit due to not being able to demonstrate each member of the workforce had participated in a formal performance appraisal process. The service implemented the following improvement actions to remediate deficits:

* A performance appraisal tracker has been introduced to record appraisal due dates and completion.
* Management advised staff performance appraisals have been conducted and are now up to date. Review of the service’s performance appraisal tracker and interviews with staff confirmed this has occurred.

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

Findings

The service has taken action to remediate deficits leading to the non-compliance in this Requirement as identified under the Site audit conducted 19-21 April 2022.

The service was found to be non-compliant in the previous Site audit due to not being able to demonstrate effective governance systems to ensure staff have access to consumer information.

Quality governance meetings now occur monthly at the service to ensure effective governance systems are in place. The service has implemented the following improvement actions to remediate deficits including additional actions in relation to workforce governance and feedback and complaints:

Information management

* The service conducted an audit to ensure staff had ready access to computer terminals and procured additional equipment. The assessment team observed numerous computer terminals available for staff throughout the service.
* Clinical staff advised they have knowledge of, and access to, information management systems to perform their roles which they can access via workstations across the service. Staff confirmed they had received education and support from the Clinical nurse educator in using the electronic care management system and can refer to a resource manual if needed.
* Management advised they monitor and support staff in using information technology systems at the service and all staff and visiting health professionals are provided with unique logins to access systems as required.
* Communication and flow of information within the service has been improved via various methods including alerts on the electronic care management system, twice daily huddle meetings, handover, and monthly staff meetings. The assessment team reviewed documentation such as monthly staff meeting schedules, meeting minutes readily available on noticeboards, revised handover templates, and observed huddles being conducted.

Workforce governance

* The service has organisational governance processes to monitor staffing, workforce training and performance management at the service with regular reporting by service management to the organisation’s People and Culture team.
* Refer to Standard 7 for further information on improvements in relation to workforce governance and to address previous non-compliance.

Feedback and complaints

* The service has organisational governance processes to monitor complaints at the service with regular monthly reporting submitted to regional management, national clinical governance meetings, and the Board.
* Refer to Standard 6 for further information on improvements in relation to feedback and complaints.

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