Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Old Timers |
| Service address: | 445 Stuart Highway ALICE SPRINGS NT 0870 |
| Commission ID: | 6983 |
| Approved provider: | Australian Regional and Remote Community Services Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 10 January 2023 to 11 January 2023 |
| Performance report date: | 23 February 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 Old Timers (**the service**) has been prepared by M Glenn, 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 consumers, representatives, staff and others;
* the provider’s response to the Assessment Team’s report received 1 February 2023;
* the Performance Report dated 22 September 2021 for an Assessment Contact undertaken from 13 July 2021 to 14 July 2021; and
* the Performance Report dated 18 June 2021 for an Assessment Contact undertaken from 9 February 2021 to 11 February 2021.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **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.

**Standard 6 Requirement (3)(d)**

* Review processes to ensure all feedback and complaints are captured, including those received verbally, to enable emerging trends and improvement opportunities to be identified.

**Standard 8 Requirement (3)(c)**

* Review the organisation’s governance systems in relation to feedback and complaints.
* Ensure consumers are supported and encouraged to provide feedback and make complaints and that feedback received is documented and used to improve quality of care and services.
* Ensure staff are aware of the organisation’s feedback and complaints processes.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 9 February 2021 to 11 February 2021 where it was found risks related to activities consumers chose to partake in were not consistently identified and considered. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, implementing risk assessments to assess and mitigate risks relating to activities consumers choose to partake.

At the Assessment Contact undertaken from 10 January 2023 to 11 January 2023, completion of risk assessments were found to be part of the entry process, with regular reviews undertaken to ensure effectiveness. For consumers who partake in activities which include an element of risk, risk assessment consent forms had been completed in consultation with consumers and/or representatives and risk mitigation strategies had been developed. Risk taking activities are included in the High-risk register and discussed by the management team on a weekly basis. Staff described how they support consumers to take risks and strategies they implement to mitigate risks. Consumers sampled felt supported to take risks that enable them to live their best life and recalled staff discussing risks and mitigation strategies with them.

For the reasons detailed above, I find Requirement (3)(d) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 9 February 2021 to 11 February 2021 where it was found consumers’ advance care planning and end of life planning wishes had not been consistently identified or addressed. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, recording a statement in the files of consumers under the care of the Public Guardian to contact the Guardian in the event end of life discussions are to be made; and making it a mandatory requirement that advance care directives are obtained as part of the admission process for all consumers.

At the Assessment Contact undertaken from 10 January 2023 to 11 January 2023, care files sampled identified most consumers’ current needs, goals and preferences, including end of life directives. Monitoring processes, such as audits and progress note reviews, ensure assessment and planning is accurate and current. Care and clinical staff described personalised needs, preferences, and management strategies for sampled consumers, and agency staff confirmed care plans and assessments contain sufficient information to convey consumers’ needs, goals and preferences. Two consumers confirmed staff had used assessments to identify their needs, goals and preferences and agreed their care needs are addressed, however, said agency staff sometimes need reminding about individual preferences.

For the reasons detailed above, I find Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers 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

Requirement (3)(a) was found non-compliant following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021 as the service did not demonstrate effective identification and management of pressure injuries and wound care. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, reassessed consumers’ pressure injury risk and updated care plans; ordered additional aids and equipment; engaged with the ‘PainChek’ program, with the PainChek used twice each day and as needed; developed a clinical risk register to identify high risk and ensure risks are appropriately managed and monitored; and commenced staff huddles to provide a structured approach and supportive clinical environment for discussing changes in consumers’ health status and care needs.

At the Assessment Contact undertaken from 10 January 2023 to 11 January 2023, it was found that validated risk assessments are utilised on entry and on an ongoing basis to identify consumers’ personal and/or clinical care needs and preferences, with information gathered used to develop individualised care plans aimed at optimising health and well-being. Care files sampled, and feedback from clinical and care staff demonstrated, appropriate management of consumers’ personal and clinical care needs, including in relation to wounds and behaviour management. Care files for two consumers demonstrated that while falls had been managed in line with the falls protocol and strategies to reduce the risk of further falls had been implemented, neurological observations had not been consistently undertaken at the required time intervals. However, documentation demonstrated both consumers were monitored for 24 hours with the frequency of falls noted to have reduced. All consumers and representatives expressed satisfaction with personal and clinical care, including in relation to showering and management of continence and medications.

For the reasons detailed above, I find Requirement (3)(a) in Standard 3 Personal care and clinical care compliant.

# Standard 6

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

Findings

The Quality Standard is assessed as non-compliant the one specific Requirement assessed has been found non-compliant.

The Assessment Team recommended Requirement (3)(d) in Standard 6 Feedback and complaints not met as they were not satisfied feedback and complaints were consistently reviewed and used to improve care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* There is no policy or procedure to guide staff in documenting, trending and analysing of feedback and complaints.
* The Plan for continuous improvement (PCI) included limited improvements resulting from feedback and complaints.
* Complaints data for the six months prior to the Assessment Contact included only five complaints. The data included minimal content and did not show how these were reviewed or if they had been actioned through to closure. The data did not include all feedback and complaints, particularly those provided verbally.
  + Five of nine consumers expressed dissatisfaction with the food and some indicated they had raised this previously with staff. Complaints data showed only one complaint related to dissatisfaction with food.
  + Consumers said they have provided feedback and no longer raise any suggestions or concerns, as nothing changes when they do.
* A suggestions/complaints box was observed located high up on the wall with two different versions of the complaint form. Two forms were found in the box dated September 2022 and May 2021 respectively. The complaints had not been logged through the service’s system.
* Most staff said they receive verbal feedback from consumers and will either action at the time, tell the nurse in charge, or may write something in a progress note. Staff did not display knowledge of processes to record feedback and complaints and how these were reviewed.
* Management acknowledged there was currently no clear system and guidance for staff for capturing verbal feedback and encouraging consumers to provide feedback and were, therefore, not reviewing or actioning on a consistent basis.

The provider’s response included commentary providing further clarification of information in the Assessment Team’s report, as well as supporting documentation and actions taken in response to deficits identified. The response also included a PCI directly addressing deficits highlighted in the Assessment Team’s which outlined corrective actions required and planned outcomes. The provider’s response included, but was not limited to:

* The Assessment Team were provided the new version of the Complaints procedure rather than the current version, which was superseded in December 2022. The latest policies articulate the new documentation process for feedback using the electronic system. The provider concedes the policy and procedure changes were not finalised at the time of the Assessment Contact and this may have left staff with uncertainty about the process.
* Updated all posters requesting feedback and ensured feedback forms are available.
* Added the invitation to feedback option in the monthly newsletter and ensured a page is populated with positive changes in response.
* Provided education to managers and staff with regard to collecting feedback in line with the new protocol.
* Reinforced feedback opportunities to be provided through consumer, representative and staff meetings.

I acknowledge the provider’s response. However, I find at the time of the Assessment Contact, the service did not demonstrate a best practice system to manage feedback and complaints.

I have considered the service has not effectively used the feedback and complaints system to identify improvements to care and service delivery. Complaints data only included five complaints received in the six months preceding the Assessment Contact and did not include any feedback received verbally. Most staff indicated they receive verbal feedback from consumers, however, they did not demonstrate knowledge of how this is to be recorded. This was supported by feedback from the majority of consumers who indicated they had provided feedback to staff relating to specific areas of dissatisfaction, however, only one complaint was reflected in complaints data. I have also considered that consumers indicated that while they have provided feedback, they no longer raise any suggestions or concerns, as nothing changes when they do. As such, I have considered that by not capturing, documenting and analysing feedback and complaints, specifically those received verbally, this has not provided the service an opportunity to identify emerging trends or implement improvement initiatives in response, which has the potential to result in ongoing issues. I find this has not ensured that all feedback is considered or used to identify trends or enabled improvements to the quality of care and services to be identified and implemented.

In relation to policy documents, actioning and review of complaints data, the suggestion box and a system and guidance to capture verbal feedback, I have considered this evidence is more aligned with the organisation’s overall feedback and complaints governance system. As such, I have considered the evidence and the provider’s response in my finding for Requirement (3)(c) in Standard 8 Organisational governance.

For the reasons detailed above, I find Requirements (3)(d) in Standard 6 Feedback and complaints non-compliant.

# 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)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |

Findings

Requirements (3)(a) and (3)(b) were found non-compliant following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021 where it was found:

* the number and mix of the workforce was not sufficient, impacting consumers’ care and services; and
* feedback from staff, consumers, representatives and others identified concerns with the manner in which consumers were treated.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Completed two staggered intakes of overseas staff and worked in conjunction with an external registered training organisation to develop course content and delivery for overseas staff.
* Staff have undertaken cultural awareness training to encourage understanding of consumers from a First Nations background
* Completing Life stories for all consumers on entry to provide staff with information that influences care and interactions with consumers
* Increased performance management of staff who are not interacting with consumers in an appropriate or respectful manner.

At the Assessment Contact undertaken from 10 January 2023 to 11 January 2023, the service demonstrated staffing levels and mix of staff was adequate to meet the needs of consumers, with contingencies for planned and unplanned leave to ensure provision of care and services is maintained. The majority of staff across different areas of the service said there were enough staff to provide care and services and there are processes to manage staffing shortfalls. Consumers were generally satisfied with staffing levels and indicated they do their job well.

Staff were observed to interact with consumers in a kind and respectful manner. Consumer preferences and cultural requirements are documented in care plans to guide staff, and staff sampled talked confidently to the needs and preferences of consumers. Staff were familiar with how to escalate concerns if they believed staff were treating consumers poorly and confirmed they had undertaken training in elder abuse. Management confirmed there had been no complaints, feedback or incidents in relation to poor staff practice in the past six months.

For the reasons detailed above, I find Requirements (3)(a) and (3)(b) in Standard 7 Human resources 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. | Non-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 (3)(c)**

Requirement (3)(c) was found non-compliant following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021 where it was found the service did not demonstrate effective governance systems in relation to feedback and complaints, continuous improvement and workforce governance.

The Assessment Team’s report for the Assessment Contact undertaken from 10 January 2023 to 11 January 2023 indicated management were limited in their ability to provide commentary on specific actions taken to address deficiencies identified as neither were present at the previous assessment. However, the Assessment Team found organisation wide governance systems relating to information management, financial governance, workforce governance and regulatory governance were effective. However, the Assessment Team were not satisfied with the effectiveness of governance systems relating to continuous improvement and feedback and complaints. The Assessment Team provided the following evidence and information collected through interviews and documents which are relevant to my finding:

Continuous improvement

* A PCI, last updated in December 2022, recorded one entry for Standard 8(3)(c). There were no specific entries in relation to feedback and complaints, continuous improvement, or workforce governance. Three entries were noted under Standard 6 with some correlation to feedback and complaints.
* The PCI recorded a total of 20 improvements, with 10 relating to Standards 2 and 3. The source of improvement was recorded as internal auditing. The service did not indicate any specific audits or surveys had been completed for the remaining Standards.
* Management indicated actions for improvement were occurring, providing two examples and indicated the PCI is discussed at clinical governance meetings.

Feedback and complaints

* Complaints data for the six months prior to the Assessment Contact included only five complaints, with the most recent entry dated October 2022. The data included minimal content and did not show how these were reviewed or if they had been actioned through to closure. Management indicated the complaints had been actioned and closed.
* The Comments/complaints item in minutes for the two Resident meetings held in 2022 contained no responses from consumers. The minutes did include a reminder to speak with management or staff if consumers had anything they wished to discuss.
* The majority of consumers were either unsure of the feedback and complaints process, or said they no longer gave feedback or made a complaint as nothing changed when they did.
* Most staff said they receive verbal feedback from consumers and will either action at the time, tell the nurse in charge, or they may write something in a progress note. Staff did not display knowledge of processes to record feedback and complaints and how these were reviewed.
* Minimal signage was observed throughout the service to encourage and promote consumer and staff feedback. Signage was limited to the front foyer and accessed via a QR Code. There was no signage or forms displayed in other languages or in pictorial form for non-literate consumers.
* Management acknowledged that not all feedback from consumers and staff, especially verbal, was being captured, nor was there a clear process outlined on how this was documented, actioned and reviewed to promote continuous improvement.

In coming to my finding for this Requirement, I have also considered evidence documented in the Assessment Team’s report under Standard 6 Feedback and complaints Requirement (3)(d), including in relation to policy documents, actioning and review of complaints data, the suggestion box and a system and guidance to capture verbal feedback.

I have also considered evidence indicating staff have access policies and procedures through an electronic documentation system and organisational intranet. There are processes to ensure policy and procedure documents are reviewed and updated to ensure currency. A Risk and compliance committee assists the Board in undertaking financial reporting requirements and the Service manager has a delegation of expenses. The organisation has various initiatives for recruiting and accessing staff to the region, with consideration for trainee and graduate programs, career pathways, renumeration and grant funding. There are processes to identify and implement legislative changes with regulatory compliance overseen at an organisational level.

The provider’s response included commentary providing further clarification of information in the Assessment Team’s report, as well as supporting documentation and actions taken in response to deficits identified. The response also included a PCI directly addressing deficits highlighted in the Assessment Team’s which outlined corrective actions required and planned outcomes. The provider’s response included, but was not limited to:

* An extensive Continuous improvement plan (CIP), developed in response to Sanctions imposed in July 2021 has been worked through and finalised. A new CIP was developed in February 2022 and as clinical care has been a major focus, this has featured in the CIP. The CIP has been further updated to include appropriate documentation, analysis and response to feedback received.
* Concede feedback has not been routinely documented, although it has been sought through a number of channels. The provider is assured that complaints are actioned as they are received, but note indication from some consumers that they have not had their concerns addressed and no longer raise them.

I acknowledge the provider’s response. I find at the time of the Assessment Contact, the service demonstrated effective organisation wide governance systems relating to continuous improvement, information management, financial governance, workforce governance and regulatory compliance. However, I find governance systems relating to feedback and complaints were not effective to ensure accountability and action at all levels of the organisation.

In coming to my finding, I have considered the service’s overall feedback and complaints processes have not been effectively implemented. I acknowledge the provider’s response indicating policies reflective of the new feedback documentation process had not been finalised at the time of the Assessment Contact. However, while policies in relation to feedback processes were available to guide staff, feedback, particularly verbal feedback, was not being documented to enable trends to be identified and improvements implemented. Only five complaints had been recorded in the six months preceding the Assessment Contact. There was minimal signage available promoting feedback and complaints processes and suggestion boxes were not easily accessible to consumers. Additionally, two complaints dated September 2022 and May 2021 were found in the suggestion box which had not been identified by the service. I have also considered that the majority of consumers were either unsure of the feedback and complaints process and or indicated they no longer provide feedback or make complaints as nothing changed when they did.

In relation to continuous improvement, I have considered the service has demonstrated effective systems and processes to assess, monitor and improve the quality and safety of care and services provided by the organisation. A PCI is maintained and includes improvements identified by the service through their own monitoring processes. The provider’s response indicates clinical care has been a major focus, so it is not unreasonable to expect that this is reflected on the PCI. I have also considered that in response to findings of non-compliance identified following an Assessment Contact undertaken in July 2021 and a Site Audit undertaken in February 2021, the service has implemented a range of actions which has resulted in the majority of the Requirements being found compliant following the most recent Assessment Contact undertaken in January 2023.

For the reasons detailed above, I find Requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021 where it was found the service did not demonstrate effective risk management systems and practices, specifically relating to management of pressure injuries.

The Assessment Team’s report for the Assessment Contact undertaken from 10 January 2023 to 11 January 2023 provided evidence of actions taken to address deficiencies identified, including, but not limited to, updated all consumer care plans with appropriate risk assessments, monitoring and review strategies in relation to pressure injuries and wounds; completed Risk assessment consent forms for all consumers who choose to undertake risk activities; and provided mandatory and ongoing training for staff in relation to the Serious Incident Response Scheme (SIRS), elder abuse, understanding dignity of risk and dignity and respect in aged care

The service demonstrated an effective risk management framework, supported by policy documents and clinical governance oversight, to manage risk and respond to incidents. Management and staff provided examples of risk and how these are controlled within the service. Monthly Clinical governance committee meetings are held and include discussions relating to clinical risks, incident management/SIRS reporting, adverse events, staff education and training. Pressure injuries and wounds are monitored and discussed weekly, with data reported quarterly to the Board. Care files sampled for three consumers demonstrated appropriate assessments are completed and strategies developed in relation to activities they choose to partake in which includes an element of risk. Consumers confirmed they felt supported to take risks that enable them to live their best life. Staff were knowledgeable of consumers with high impact or high prevalence risks and described strategies to mitigate risks in line with the service’s risk framework.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance 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)