Performance

Report

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| Name: | Palm Lake Aged Care Deception Bay |
| Commission ID: | 5747 |
| Address: | 42-46 Bay Street, Deception Bay, Queensland, 4508 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 10 October 2023 to 11 October 2023 |
| Performance report date: | 16 November 2023 |
| Service included in this assessment: | Provider: 6794 Palm Lake Care Operations Pty Ltd  Service: 6822 Palm Lake Aged Care Deception Bay |

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 Palm Lake Aged Care Deception Bay (**the service**) has been prepared by B Bassett, 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 30 October 2023.

# Assessment summary

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| 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 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

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |

Findings

The service was found non-compliant in Requirement 1(3)(a) following the Site Audit conducted from 14 March 2023 to 16 March 2023. Deficiencies related to consumers and representatives expressing fear and psychological distress due to a number of incidents involving another consumer in the service known to have challenging behaviours.

The service has taken actions to address these deficiencies, including;

* Providing addition face to face and on the job dementia training to staff
* Employing extra staff in the Memory Support Unit (MSU), to provide one-to-one care to consumers with challenging behaviours.
* Engaging a counselling service to provide support to consumers, representatives and staff.
* Reviewing the care plans for consumers with challenging behaviours and working with external dementia specialists to obtain assessments and implement strategies for managing challenging behaviours.
* Conducting monthly meetings with consumers and representatives to ensure any concerns were noted and could be addressed.

Consumers and representatives said they feel safe at the service, staff know consumers as individuals and are respectful of their culture and diversity. Consumers said they feel comfortable with staff are providing them care and services.

The service had policies and guidelines to guide staff in respectful communication with consumers and care documentation identified the individual preferences, culture and background of consumers.

The Assessment Team observed staff engaging positively with consumers and speaking with them in a kind and respectful manner.

After considering the above information, I am confident the service has addressed the previous deficiency and acknowledges the culture, diversity and individuality of consumers. I have therefore decided that Requirement 1(3)(a) is compliant.

The service was found non-compliant in Requirement 1(3)(c) following the Site Audit conducted from 14 March 2023 to 16 March 2023. Deficiencies identified related to some consumers not being supported to make decisions about how their care and services were delivered.

The service has taken actions to address these deficiencies, including;

* Reviewing and updating consumer care plans to reflect consumers’ choice and preferences.
* Providing training to staff in relation to consumer dignity, choice and decision making.
* Increased daily round monitoring by management to assess consumer satisfaction with services provided.
* Ensuring that consumers were provided meals of their choice.
* Conducting monthly meetings with consumers and representatives to ensure they were satisfied with actions taken by the service in relation to these issues.
* Conducting spot audits on the Standard 1 Requirements.

Consumers and representatives said consumers feel supported to exercise choice and independence in decision making. Consumers were able to provide examples of how the service assisted them to exercise their choices with respect to activities, food and personal cares.

Staff demonstrated knowledge of consumers’ care preferences and described how they supported consumers to maintain relationships with family and friends.

Care documentation contained up to date information concerning consumers’ individual preferences, the people important to them and who to involve in decisions about consumer care.

Taking into consideration the information discussed above, I am confident the service has addressed the previous deficiencies and is supporting consumers to make decisions about how their care and services are delivered. I have therefore decided that Requirement 1(3)(c) is Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The service was found non-compliant in Requirement 3(3)(b) following the Site Audit conducted from 14 March 2023 to 16 March 2023. Deficiencies identified related to time specific medication not always being administered to consumers as required and care documentation not identifying effective management strategies for consumers with challenging behaviours.

The service has taken actions to address these deficiencies, including;

* Identifying the root causes for issues impacting upon medication management. These were noted as a lack of documentation, issues with ordering and obtaining stock and inconsistency with medication charting.
* Updating the medication management system to enable improved oversight by clinical staff.
* Implementation of an alert in the electronic medication system for all time critical medications and audits of time specific medication administration.
* Meeting with Medical Officers (MO) to discuss availability of medications at the start date of prescriptions.
* Education and training of staff regarding medication administration, including documentation and mandatory reporting of incidents.
* Review and updating of all Behaviour Support Plans (BSP) for consumers with challenging behaviours. This included the development of individualised strategies for consumers in consultation with their representatives.
* Training and education on charting behaviours and evaluation of strategies used to manage challenging behaviours.

Consumers and representatives said consumers receive the care they need when they need it. Consumers receiving time sensitive medications, experiencing weight loss, falls or complex wounds said they felt safe and confident in the care they were provided.

Staff demonstrated awareness of the electronic medication system and its documentation requirements. Staff articulated specific strategies for consumers for reducing instances of challenging behaviours. Staff said they could contact specialists or otherwise escalate concerns for clinical care as required.

Review of care documentation indicated effective care planning and management with evidence of auditing of documentation. Care documentation recorded management strategies for high impact and high prevalence risks for consumers.

Meeting minutes confirmed the service had weekly and monthly clinical risk meetings to discuss risks to consumers including behaviour management, falls, wounds, unplanned weight loss and pain. The service had policies and procedures in place to guide staff.

Taking into consideration the information discussed above, I am confident the service has addressed the previous deficiencies. I have therefore decided that 3(3)(b) is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| 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 was found non-compliant in Requirement 6(3)(a) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies identified concerned consumers and representatives not feeling supported to make complaints or provide feedback. While consumers said they felt comfortable with raising concerns they were not confident they would be addressed.

Management advised they have worked to address the deficiencies and embed a supportive complaints process at the service by various actions, including;

* Ensuring feedback mechanisms are included in consumer newsletters and information is placed on notice boards throughout the service. The service also holds a monthly meeting where consumers and representatives are able to discuss issues with management.
* Staff are educated on feedback processes during orientation and all staff were reminded of their responsibilities to assist and encourage consumers in providing feedback during staff meetings and training sessions. Meeting minutes and training records confirm this has occurred.
* The service provides regular updates on feedback, complaints and suggestions received to managers and staff.

Consumers and representatives said they felt encouraged to provide feedback. Some consumers confirmed they participate in consumer meetings and focus groups and were confident their concerns would be addressed.

Staff were able to describe how they encourage consumers and representatives to provide feedback or raise concerns both through formal and informal mechanisms such as satisfaction surveys, suggestion forms or direct discussions with staff and management.

The Assessment Team observed feedback, complaint and suggestion forms were readily available to consumers and representatives in communal areas throughout the service.

After considering the above information, I am confident the service has taken appropriate actions to remedy the previous deficiencies. I therefore find Requirement 6(3)(a) Compliant.

The service was found non-compliant in Requirement 6(3)(c) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies identified concerned the service’s complaint register not evidencing documentation of some consumers’ complaints.

The service has taken actions to address the previous non-compliance, including;

* Ensuring all complaints and feedback are acknowledged by the Service Manager. The information is recorded electronically and allocates a responsible person and timeframe for the matter to be addressed.
* Complaint data is entered into reporting systems daily to ensure department heads are kept informed of any issues raised and their progress towards resolution.
* The service’s complaint register and consumer meeting minutes confirmed concerns raised were documented and monitored for progress towards resolution.

Consumers who had submitted feedback or complaints confirmed they had received acknowledgement of their feedback and said they were satisfied with the response from management. They provided examples of how they had raised concerns in relation to activities, food and waiting times for care and these had been addressed.

Staff and management were able to describe the processes for receiving and actioning concerns and complaints including ensuring the matter is fully documented and using open disclosure where appropriate.

Following consideration of the above information I have decided the previous deficiencies have been remedied by the service and consumer complaints are being accurately recorded and actioned. I therefore find Requirement 6(3)(c) Compliant.

The service was found non-compliant in Requirement 6(3)(d) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies identified concerned the service not being able to demonstrate that consumer and representative feedback was used to improve the quality of care and services.

The service has taken actions to address this deficiency, including;

* Management review complaints and feedback to determine how they can inform the service’s Plan for Continuous Improvement (PCI), and if the suggestions can be implemented, they are added to the PCI for action.
* Providing regular feedback at consumer meetings regarding development of the PCI at the service and giving consumers current information concerning improvements being undertaken.

A review of the service’s PCI confirmed consumer feedback has informed improvements at the service. Examples included refurbishment of garden areas and purchase of mini golf equipment. At the request of consumers, education has been provided to them regarding support available for those with hearing impairment. Different topics are planned for consumers in the future.

Consumers and representatives could describe changes made to care and services as a result of their complaints or suggestions. For example, consumers requested the re-introduction of bus outings, and these were implemented.

Staff and management were able to provide examples of where consumer feedback had been used to inform service improvements. Staff and management were able to describe the process by which matters raised by consumers are entered into the feedback and complaints system and how the data is used to inform the service’s PCI and is reported to higher management.

Following consideration of the above information I have decided consumer complaints and feedback is informing improvements in the service. I therefore find Requirement 6(3)(d) 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 |

Findings

The service was found non-compliant in Requirement 7(3)(a) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies concerned consumers, representatives and staff saying there were not enough staff at the service to meet consumer needs in a timely manner. Consumers said they had to wait long periods of time for a response to their use of call bells and felt rushed during the provision of cares.

The service has taken actions to remedy the identified deficiencies, including;

* Developing a detailed workforce plan to manage staffing at the service. This included seeking feedback from consumers, representatives, and staff regarding staffing issues.
* Purchasing 10 walkie talkies for staff to be able to request assistance from other staff whenever required. Staff said this saves them significant time when they need help to deliver cares.
* Developing a new duty guideline in consultation with staff, which allocates duties to be undertaken and the time allocated to perform the task.
* Conducting regular call bell audits to ensure consumers are attended to in a timely manner. Any response times outside of the expected time are investigated.
* Management conducts daily rounds of the service to gather information from consumers as to the performance of staff in relation to the delivery of care and services.

Consumers said staff respond to their requests for assistance in a timely manner and provide care and services in line with their preferences. Consumers and representatives said staffing levels had greatly improved and consumers received care at the time of their choosing. Consumers confirmed they see management conducting regular rounds of the service and can talk to them about any issues. Consumer meeting minutes evidence positive feedback from consumers and representatives regarding staffing changes made since the Site Audit conducted from 14 March 2023 to 16 March 2023.

Staff advised there are sufficient staff members to provide care and services in accordance with consumers’ requests and that staff are usually replaced when there is an unplanned absence. Staff said they were comfortable in raising any staffing issues with management and they have time to complete all their duties in line with the new duty guidelines.

Review of roster and allocation documentation demonstrated the service has a full complement of registered staff available and most shifts are fully filled. Where gaps were evidenced, they were filled by staff doing additional hours or through the use of agency staff. Call bells audits demonstrated significant improvement in response times since the Site Audit conducted in March 2023.

Staff meeting minutes confirmed discussions regarding staffing levels and feedback on improvements. Staff expressed satisfaction with staffing levels, and said they now have time to perform their duties. Staff surveys indicated high levels of satisfaction from staff regarding their ability to raise any issues with management.

Management demonstrated a monitoring and evaluation process to ensure a planned workforce. This included monitoring of call bell records, feedback on care delivery and investigation of any issues. Management advised they were able to adjust staffing levels in different areas of the service when workloads change, for example, due to a change in the condition of consumers or an increased need for two person assists with lifting.

Having taken into consideration the above information, I am confident the service has remedied the previously identified deficiencies and the workforce is planned and managed to provide quality care and services. I therefore find Requirement 7(3)(a) Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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

The service was found non-compliant in Requirement 8(3)(a) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies concerned consumers and representatives saying they were not involved in improving the delivery of care and services and expressing their frustration at raising issues at consumer meetings and feeling actions were not taken in response.

The service has taken actions to address these deficiencies, including;

* Commencing regular meetings with consumers and representatives, including specific meetings with consumers in the MSU, to ensure consumers and their representatives were kept informed of changes within the service and provided opportunities to have input into the implementation of the changes.
* Consumers were invited to a consultative staff meeting to enable them to voice specific concerns and feedback directly to staff and management.
* Management increased monitoring of feedback from consumers and representatives and includes this information in reporting to the service’s executive leadership for their awareness.

Review of meeting minutes confirmed consumers and representatives are attending and contributing to discussions in consumer meetings, consultative staff meetings and food focus groups.

Consumers and representatives were able to provide examples of how their feedback has been used in the development and evaluation of services. These included the changes in staffing levels and the refurbishment of garden areas.

The service was able to demonstrate an effective reporting structure that ensures the flow of information from consumers and representatives through management to the organisation’s governing body. Information used by management to evaluate the delivery of care and services includes complaints, incidents, audit reports and consumer survey results.

Having taken into consideration the above information, I am confident the service has remedied the previously identified deficiencies and consumers are engaged in the development and evaluation of services. I therefore find Requirement 8(3)(a) Compliant.

The service was found non-compliant in Requirement 8(3)(b) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies concerned the service being unable to demonstrate a culture of safe, inclusive and quality care. This was evidenced by consumers expressing their fear of a consumer with challenging behaviours that was impacting upon their quality or life.

The service has taken actions to address these deficiencies, including;

* Holding regular meetings with consumers and representatives within the MSU to discuss any concerns they have regarding safety or other issues.
* Education and training for staff regarding management of challenging behaviours, ensuring the safety of consumers and escalation of incidents.
* Review of the entry process to ascertain the suitability and safety for all consumers entering the service.

Consumers and representatives said they feel the service is a safe place to live and trust staff to keep everyone safe. Consumers confirmed they raise issues at the consumer meetings or speak directly to staff if they have any concerns about care or safety.

The service conducts regular quality audits against the Quality Standards and uses this information in conjunction with clinical data to identify deficiencies in care, policies, or procedures. Review of the information demonstrated where issues have been identified they are added to the services PCI for action and are regularly monitored by the organisation until they are resolved.

Review of the organisation’s governance framework identifies a leadership structure with the governing body (the Board) holding overall accountability for quality and safety in the organisation.

Having taken into consideration the above information, I am confident the service has remedied the previously identified deficiencies and is promoting a culture of safe, inclusive quality care and services. I therefore find Requirement 8(3)(b) Compliant.

The service was found non-compliant in Requirement 8(3)(c) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The service did not demonstrate effective governance systems relating to information management, workforce governance, regulatory compliance or feedback and complaints.

The service has taken actions to address the identified deficiencies, including;

* Providing training to staff regarding privacy and confidentiality.
* Developing a detailed workforce plan for the service.
* Review of previously unreported Serious Incident Response Scheme (SIRS) incidents and submitting these as required. Providing education to staff regarding mandatory reporting and incident management. Management now review all progress notes to ensure incidents are identified and managed in compliance with regulatory obligations.
* Acknowledging all feedback and complaints and recording and actioning issues raised by consumers, representatives, and staff.

Consumer information is kept private and confidential. Staff confirmed they had received training regarding information management. The Assessment Team observed consumer information was kept in areas inaccessible to the public and computers were locked when not in use.

The service has an effective workforce governance framework including workforce guidance documents, processes to ensure staff are appropriately qualified and trained for their duties, position descriptions, and performance assessment processes.

Review of incident reports demonstrated compliance with legislation relevant to the SIRS and incident management requirements. Staff confirmed they had received training on the SIRS, elder abuse and neglect, and the Quality Standards. Staff could describe their responsibilities with regards to mandatory reporting.

The service demonstrated systems are in place to encourage the provision of consumer feedback and complaints and ensure appropriate action is taken. Feedback from consumers and representatives is used to inform continuous improvement processes within the service.

Having taken into consideration the above information, I am confident the service has remedied the previously identified deficiencies and is operating with effective organisation wide governance systems. I therefore find Requirement 8(3)(c) Compliant.

The service was found non-compliant in Requirement 8(3)(d) following the Site Audit conducted from 14 March 2023 to 16 March 2023. The deficiencies concerned medication incidents not reported as per SIRS requirements and under reporting in the service’s incident management system in relation to concerns raised by consumers and representatives.

The service has taken actions to address the previously identified deficiencies, including;

* Review of the service’s incident management system to ensure all incidents requiring notification to SIRS have been reported.
* Education of staff to ensure they are aware of incident management processes and mandatory reporting requirements.
* Ensuring registered staff have completed medication competency training to minimise the possibility of medication incidents.

Review of documentation and interviews with management and staff demonstrated a shared understanding of what constitutes a serious incident and how it is to be reported, including meeting reportable timeframes.

The organisation has policies and processes on 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.

Review of the incident management system and the reportable incidents register demonstrates incidents are reported to SIRS as required and other non-reportable incidents are investigated and managed through the organisation’s incident management system.

Having taken into consideration the above information, I am confident the service has remedied the previously identified deficiencies and has effective risk management systems and practices. I therefore find Requirement 8(3)(d) 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)