Performance

Report

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| Name: | Timbrebongie House |
| Commission ID: | 0284 |
| Address: | 134-138 Cathundril Street, NARROMINE, New South Wales, 2821 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 21 August 2024 to 22 August 2024 |
| Performance report date: | 10 October 2024 |
| Service included in this assessment: | Provider: 973 Timbrebongie House Limited  Service: 300 Timbrebongie House |

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 Timbrebongie House (**the service**) has been prepared by Therese Solomon, 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 27 September 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

Requirement 3(3)(a)

* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs, and optimises their health and well-being.

Requirement 6(3)(c)

* Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

Requirement 8(3)(c)

* Ensure effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

# 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. | Not Compliant |

Findings

The service did not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs, and optimises their health and well-being.

While some consumers are satisfied with the delivery of personal and clinical care, other consumers indicated they are dissatisfied with the care provided. Personal and clinical care provided to some consumers has been tailored to consumers’ needs and has optimised their health and well-being.

However, incident management has not been thorough. Factors contributing to incidents were not investigated and measures to prevent future incidents were not identified or implemented. Assessment following incidents is not always undertaken. Follow up after a fall occurred was not best practice and pain is not consistently monitored or assessed. Not all consumers are provided with meals of the correct texture and assistance and meal assistance for one consumer was not safe or best practice.

Deficiencies included:

* Dissatisfaction reported by a representative in relation to inadequate personal care provided to a consumer.
* An undignified incident related to a consumer being left unattended for an extended period of time.
* Observations show consumers requiring modified textured meals receiving incorrect meals, placing consumers at risk of harm.
* A consumer requiring assistance with meals receiving her meal in an undignified and unsafe manner.
* Inadequate pain management for a consumer after an incident occurred.
* Lack of comprehensive incident investigation for consumers to identify contributing factors.
* A nutrition and hydration care plan was inconsistent, contained contradictory information and was not reflective of the consumer’s current needs.

The Approved Provider’s response submission acknowledged the findings contained in the Assessment Contact report and included a plan for continuous improvement containing actions to address the identified non-compliance, including education and training for staff.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including further education and training for staff and have taken immediate action in response to certain areas of the Contact Assessment report including following up with consumers named in the report and are committed to understanding consumers feedback and working with them towards resolving their concerns.

This requirement requires that each consumer receives safe and effective care and services, that is best practice, tailored to their needs and optimises their health and well-being. The service has not demonstrated that all consumers receive safe and effective care and services, that is best practice, tailored to their needs and optimises their health and well-being, and the response submission acknowledged these examples. Therefore, it is my decision requirement 3(3)(a) is non-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. | Not Compliant |

Findings

The service did not demonstrate that appropriate action is taken in response to complaints. Consumers and/or representatives provided mixed feedback about whether their complaints and concerns are being satisfactorily addressed. The complaints register does not capture complaints and feedback raised by consumers during resident meetings, and most staff interviewed were unaware of the concept of open disclosure.

The complaints register shows 12 complaints to date in 2024, with 9 complaints closed and 3 complaints remaining open. The complaints register shows the majority of the complaints have been closed with a response action noting that the ‘CEO investigated’, however there are no details of the actions taken, effectiveness of actions or satisfaction of the complainant with the action taken. The Assessment Team reviewed 3 feedback and complaint forms submitted in 2024. The complaint and feedback form includes an ‘our actions’ section that has been left blank with no information pertaining to the actions taken to address the complaint, however the complaints have been noted as closed on the complaints register. Management acknowledged the feedback provided by the Assessment Team and did not provide a response during the visit.

The Assessment Team reviewed resident meeting minutes dated 12 August 2024, that included feedback from consumers stating they are not consistently treated with dignity and respect by staff, and 5 complaints related to meals, however none of the raised feedback or complaints have been captured in the complaints register and there was no documentation to demonstrate that action had been taken in response to the complaints.

The Assessment Team provided feedback about complaints not being captured to management; however, management was not able to demonstrate an understanding of capturing all feedback and complaints in the complaints register. The CEO indicated they consider there is a difference between formal complaints and feedback and that the complaint register was only for recording formal complaints.

Deficiencies included:

* A consumer reported not attending consumer meetings due to the lack of response and feedback in relation to complaints.
* A consumer stating she would like to make a compliant, however felt there would be not point as she feels that the service does not care.
* A consumer representative stating the service is not interested in her feedback and that things do not improve when she has provided feedback, specifically related to feedback given in response to meals and the provision of personal care.
* Feedback received from multiple consumers, representatives and staff who wish to remain anonymous stated that some senior management members are not approachable and have been observed yelling at staff members.
* 5 Out of 6 staff members did not demonstrate and understanding of open disclosure.
* A consumer requiring assistance with meals receiving her meal in an undignified and unsafe manner.
* No training records were provided to demonstrate staff had received education related to open disclosure.

The Approved Provider’s response submission acknowledged the findings contained in the Assessment Contact report and included a plan for continuous improvement containing actions to address the identified non-compliance.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including further education and training for staff; and have taken immediate action in response to areas of the Contact Assessment report including following up with consumers named in the report and are committed to understanding consumers feedback and working with them towards resolving their concerns.

This requirement requires that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The service has not demonstrated that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong, and the response submission acknowledged these examples. Therefore, it is my decision requirement 6(3)(c) 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. | Not Compliant |

Findings

The organisation did not demonstrate effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

In relation to information management, care documentation did not consistently capture accurate information about consumers’ needs and preferences. Documentation about incident management, including investigation, is limited and does not support the development of comprehensive measures to prevent future incidents. Pain monitoring and other care is not always documented. Assessments to support the development of interventions to care needs are not always undertaken. Policies and procedures are not always comprehensive, reflective of best practice, and did not demonstrate thorough review.

In relation to continuous improvement, the service does not have systems in place to identify deficiencies in care and services and support the development and implementation of continuous improvement opportunities. Review of the plan for continuous improvement shows minimal improvement opportunities have been captured and actions do not demonstrate how issues are addressed.

The service has a continuous improvement plan in place and some improvement activities have been undertaken, including refurbishment of some consumer rooms currently being undertaken and a new call bell system. However, the organisation did not demonstrate that, improvement activities respond to the needs of the service and consumers or that improvements are monitored for effectiveness. The organisation did not demonstrate planning for the implementation of the call bell system was thorough, considered the risks to consumers and the implementation has not been monitored to ensure the improvement is effective and meeting the needs of the service and consumers.

Observations of management and staff interactions and interviews undertaken do not demonstrate that the organisation has sound workforce management strategies in place. Following observations that consumers were not provided with the texture modified meals of the correct consistency, information was requested related to the qualifications of catering staff and education that had been provided to them. No information was provided to confirm that catering staff were suitably qualified and trained.

The organisation did not demonstrate a sound understanding of their regulatory compliance obligations specifically related to environmental restraint. Discussions with staff and the CEO demonstrated a lack of understanding related to an exit door and the ability of consumers to exit the building through the door. It was noted that restrictive practice authorisations for environmental restraint was in place for some consumers but not for all consumers. Where restrictive practice authorisations were in place, the authorisations did not demonstrate that the restrictive practice was necessary or used as a last resort.

A director was asked about whether the organisation had introduced a consumer advisory committee. The director reported the Board had not considered this and they were unaware of any requirement for this to occur. When asked about approved provider responsibilities and the requirement to establish a consumer advisory body, the CEO stated they do not have a consumer advisory body as the service is not big enough.

The Approved Provider’s response submission acknowledged the findings contained in the Assessment Contact report and included a plan for continuous improvement containing actions to address the identified non-compliance.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including education and training for the CEO on feedback and complaints management for managers, update current feedback and compliant process to now include all feedback to be entered into electronic case management system for increased transparency, training to be organised for the board members to ensure members are aware of their roles and responsibilities.

This requirement requires effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. The service has not demonstrated effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints, and the response submission acknowledged these examples. Therefore, it is my decision requirement 8(3)(c) is non-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)