Performance

Report

**1800 951 822**

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| Name: | Umina Park Home For The Aged |
| Commission ID: | 8811 |
| Address: | 22-24 Mooreville Road, BURNIE, Tasmania, 7320 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 1 November 2023 to 2 November 2023 |
| Performance report date: | 13 December 2023 |
| Service included in this assessment: | Provider: 2389 OneCare Limited  Service: 5086 Umina Park Home For The Aged |

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 Umina Park Home For The Aged (**the service**) has been prepared by L Glass, 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.

# Assessment summary

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| 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 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 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

Requirements 4(3)(a) and 4(3)(f) were found non-compliant following a site audit on 21 March 2023 to 23 March 2023. The service did not demonstrate each consumer received safe and effective services and supports for daily living that met the consumer’s needs, goals and preferences that optimised their independence, health, well-being and quality of life. The service did not demonstrate meals were varied and of suitable quality and quantity.

During the assessment contact conducted on 1 November 2023 to 2 November 2023 the Assessment Team found the service has implemented several effective actions in response to the non-compliance identified at the site audit.

In relation to Requirement 4(3)(a) the service has undertaken a review of the leisure and lifestyle program, activities calendar, team structure and introduced consumer surveys. It has delivered training related to the new consumer engagement network, assessment and planning, partnership and audit collection and analysis.

The service also demonstrated each consumer receives safe and effective services and supports for daily living that meet consumer’s needs, goals and preferences to optimise their independence, health, well-being and quality of life. All consumers interviewed described satisfaction with the leisure and lifestyle program and team, activities calendar, level of consumer engagement and surveys undertaken. All staff interviewed demonstrated knowledge of individual consumers’ preferred activities of interest. All consumers leisure and lifestyle assessment and planning documentation reviewed showed information to meet consumer’s needs, goals and preferences. This included activities and engagement for including for consumers with more complex needs for example related to dementia. Observations aligned with consumer and staff feedback and documentation reviewed.

In relation to Requirement 4(3)(f) the service has implemented several effective actions in response to the non-compliance identified at the site audit. The service has undertaken a review of the dining experience and delivered training to the catering team in relation to menu choices. It has implemented a daily meal satisfaction survey and new menu. During the assessment contact conducted on 1 November 2023 to 2 November 2023, the service demonstrated meals are varied and of suitable quality and quantity. Consumers were satisfied meals are of suitable quantity however some consumers provided negative feedback in relation meal temperature and the way some items of food were served.

Management acknowledged the feedback and discussed quality control strategies in place. Management are in the process of undertaking a review of meal delivery processes and exploring alternative options.

All consumers interviewed said they have a variety of meals and snacks to choose from, felt they had a voice in relation to menu planning and said they do not go hungry. Staff demonstrated knowledge of consumers nutrition and hydration needs, goals and preferences. Consumers nutrition and hydration documentation sampled showed consistent information across assessment, planning, charting and lists. Observations noted nutrition and hydration delivery consistent with consumers needs and preferences.

All consumers interviewed confirmed they receive the meals they request, have access to readable menus in various locations, are aware of and/or participated in ‘resident’ and ‘food advisory’ meetings and related internal/external food surveys.

I have considered the evidence provided in the Assessment Team report and the recommendation that the Requirements are met. I find Requirements 4(3)(a) and 4(3)(f) 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

Requirements 6(3)(c) and 6(3)(d) were found non-compliant following a site audit on 21 March 2023 to 24 March 2023. The service did not demonstrate it took appropriate action in response to complaints, nor that it always used an open disclosure process when things went wrong. The service at that time was not able to demonstrate feedback and complaints were reviewed and used to improve the quality of care and services. The organisation has implemented effective actions in response to the non-compliance identified at the site audit.

In relation to Requirement 6(3)(c) the service ensures that complaints and feedback are recorded and responded to in a timely manner. Staff are trained in complaint handling and use the practice of open disclosure when something goes wrong. During the assessment contact conducted on 1 November 2023 to 2 November 2023, the service demonstrated it takes appropriate action in response to complaints and always uses an open disclosure process when things go wrong. All consumers and/or representatives interviewed said management address and resolve concerns raised and respond appropriately to complaints. All care staff interviewed were familiar with the term open disclosure, demonstrated an understanding of the process and explained how they apologise to a consumer when incidents happen, or when something goes wrong. All care staff interviewed said they refer all incidents directly to clinical staff immediately and seek advice. Management explained how staff are guided by policies on open disclosure and complaints management. Documentation review evidenced that appropriate action is taken in response to complaints and information is recorded for trending and analysis.

The service’s complaint policy includes principals and support processes relating to complaints, feedback, and open disclosure. The document outlines that the feedback management system has the consumer at the centre of the process and that they should be reassured by staff not to be afraid to provide feedback.

In relation to Requirement 6(3)(d) The organisation has implemented actions in response to the non-compliance identified at the site audit which have been effective. The service regularly reviews all compliments, feedback and complaints in a timely manner. Trends in complaint data, audit results and feedback is used to drive change within the service and recorded with the plan for continuous improvement.

During the assessment contact conducted at the service on 1 November 2023 to 2 November 2023, management outlined that they actively monitor feedback and complaints received in both oral and written form. They stated feedback and complaints are immediately entered into the electronic management system and acted upon. Complaint and feedback data is used to drive continuous improvement and is recorded appropriately.

I have considered the evidence provided in the Assessment Team report and the recommendation that the Requirements are met. I find Requirements 6(3)(c) and 6(3)(d) 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 |

Findings

This Requirement was found non-compliant following a site audit on 21 March 2023 to 24 March 2023, the service did not demonstrate consumers were engaged in the development, delivery and evaluation of care and services and were supported in that engagement. During the assessment contact conducted on 1 November 2023 to 2 November 2023 the Assessment Team found the service has implemented actions in response to the non-compliance identified at the site audit which have been effective.

The Assessment Team found the service engages with consumers through audits, direct communication and consumer meetings. The service ensures that monthly meetings with consumers and their representatives outline clinical indicators, quality initiatives and incidents,

And changes and improvements to the care and services delivered. Feedback is sought on changes and improvements implemented. Management outlined that they have updated their resident and relative meeting agenda to ensure consumers are advised and engaged in changes within the service to care and services. The meeting agenda allows for comment and feedback therefore ensuring transparency to consumers and the representatives.

The service demonstrated there are organisation wide governance systems to support effective information management, continuous improvement, regulatory compliance and feedback and complaint management. The Board monitored and reviewed routine reporting and analysis of data related to consumer experience.

I have considered the evidence provided in the Assessment Team report and the recommendation that the Requirements are met. I find Requirement 8(3)(a) 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)