Performance

Report

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| Name of service: | A H Orr Lodge |
| Service address: | 31 Clissold Street ASHFIELD NSW 2131 |
| Commission ID: | 0007 |
| Approved provider: | Ashfield Baptist Homes Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 August 2023 to 3 August 2023 |
| Performance report date: | 15 September 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 A H Orr Lodge (**the service**) has been prepared by T 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 - 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 provider’s response to the assessment team’s report received 29 August 2023.

# Assessment summary

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| 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 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Compliant** |

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 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| 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 |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated processes are in place to ensure all relevant information is captured during assessment and planning to ensure safe and effective care and services are delivered to consumers. Care planning documentation shows a range of validated clinical risk assessment tools are completed upon admission, including skin, mobility, nutrition and hydration, falls, behaviour, medication, and, if required, wound and diabetes management.

Clinical staff described the process of assessment and the information obtained from a consumer and/or representative on the first day of admission, identifying potential risks. During pre-admission and upon entry, consumers, along with their representatives, are interviewed and comprehensive information is obtained, including allergies, diagnosis, and alerts. Initial assessments are completed, including risk assessment, and this information is used to develop care and service plans.

Requirement 2(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated assessment and planning identifies and addresses the consumers’ current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wishes. Management and staff explained the assessment and consultation process used at the service. Documentation confirmed consumers have needs, goals, and preferences, including in relation to personal hygiene, food and nutrition, sleep, and daily activities documented. Staff were able to provide examples of consumers’ preferences in line with their care plans. Consumers had advance care directives and end-of-life care planning documented that reflects consumer wishes and preferences.

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team identified that consumer care plans are reviewed within the organisation’s recommended time period, however found care plans did not consistently reflect reviews when circumstances changed or incidents affected the consumers’ needs, goals, and preferences.

Case conferences and care consultations were offered to consumers and/or representatives in a timely manner, and consumers and/or representatives stated they had been informed when changes in the care or condition of the consumer occurred.

The Approved Provider responded with additional information and documentation.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found Compliant.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Review of care and service documentation for consumers with pressure injuries and wounds confirmed the service conducts regular reviews and delivers care and services as per the consumer’s care plan. Photographs of wounds were accurately taken to demonstrate best practices in accordance with the organisation’s wound policy, and skin assessments and skin integrity care plans were being reviewed and updated. Deterioration of wounds were recognised and referrals to external services was conducted in a timely manner.

The service demonstrated pain management was conducted within best practice guidelines and tailored to meet consumers’ needs and well-being. Consumers and/or representatives expressed satisfaction with how the service has manage their pain. A review of pain management documentation indicated pain charts are attended to when pain is recognised, monitored, or interventions reviewed.

Consumers and/or representatives stated they have access to a medical officer or other health professional when required or would like to discuss concerns. Clinical supervision is provided by the clinical manager, who provides assistance to the registered nurses on duty.

Requirement 3(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has processes in place to effectively manage high impact and high prevalence risks associated with the care of each consumer. Documentation reviewed confirmed effective management of high impact high prevalence risks, including falls, wounds, changing behaviour and weight changes.

The service has implemented and developed a clinical risk register. The high impact high prevalence risk register was designed to identify risks for individual consumers as well as provide a clinical risk profile for the service. It will provide the service with a risk summary report that offers a risk rating against a select criteria. The criteria include information related to nutrition and hydration, medication management, pressure injuries, restrictive practice, sensory impairment, infections, wounds, falls, behaviour management, complex care and more.

Requirement 3(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated they recognise and detect deterioration and/or change in consumer’s cognitive and physical function, capacity or condition and respond in a timely manner. Consumers and/or representatives reported satisfaction with how the service recognises and respond to changes in consumer health and condition and implements strategies in a timely manner to limit further health complications occurring.

Staff stated they report any changes in the consumer’s condition to the registered nurse, who then assesses the consumer. The registered nurses were able to describe how they review consumers in case of deterioration and provide required care such as attending vital observations, head-to-toe assessments, delirium screenings, and referring to a medical officer or transferring to the hospital if required.

Requirement 3(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that information about the consumer’s condition, needs, and preferences are documented and effectively communicated with those involved in the care of consumers. Consumers and/or representatives stated the consumer’s care needs and preferences are effectively communicated between staff and support the care they receive.

Handover sheets provided by clinical staff contained information necessary for safe and effective care delivery, for example, risks, current health needs, and preferences. Registered nurses and care staff were able to describe how information is shared when changes occur through handover and how changes are documented in progress notes and the handover sheet.

Requirement 3(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has a clear understanding of minimisation of infection related risks through implementation of standard and transmission-based precautions and practices. Staff are guided by the service’s infection control policy and procedures with guidance from both the infection prevention control leads and management. Registered nurses and care staff demonstrated a sound understanding of antimicrobial stewardship, infection control, and standard precautions.

The Assessment Team observed sanitising stations readily available for consumers, staff, and visitors to utilise around the facility, and education provided onsite and online for handwashing, donning and doffing, infection control, and antimicrobial stewardship.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement 4(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

A lifestyle team member advised any damaged or broken lifestyle equipment are logged into the electronic maintenance system for repair, and reported they have a budget to purchase required items for the lifestyle program. An external maintenance company has been contracted to undertake the routine servicing and inspection of equipment such as lifters to ensure these are completed on a regular basis. Consumers and/or representatives advised they felt the equipment used was kept clean and worked well.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Requirement 5(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives advised they could walk around the service environment and did not feel restricted. Several consumers reported they had lived at the service for some months or longer and were able to find their way around the service without difficulty. Outdoor furniture was observed to be clean and in good condition. Consumers and/or representatives were observed throughout the Assessment Contact utilising the central communal area near the café.

Requirement 5(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The maintenance supervisor advised the service has transitioned to an electronic maintenance system which enables staff to access the system via the service’s intranet. This system enables all staff to add maintenance reports when they observe issues and allows staff to track the completion items they log into the system. The maintenance supervisor stated he can’t close out any items until these are completed, and that he will note in the comments section any issues or delays due to waiting on external contractors or replacement parts. Several staff across lifestyle and care roles confirmed they were able to use the electronic maintenance system.

Internal doors within the service were unlocked and consumers are able to mobilise around the building if they choose to do so. Doors to external courtyards and verandas were observed to be unlocked, and consumers were able to access these if they wished to do so.

Cleaning staff undertake the periodic cleaning of furniture including outdoor items to ensure furniture is being maintained and kept clean, this was observed during the Assessment Contact.

# 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)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving 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

Requirement 6(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated a system in place that encourages consumers,their representatives, and staff to provide feedback and make complaints. Consumers and/or representatives stated they feel supported to make complaints, provide feedback and are aware of the avenues existing to support this. They described how they provide feedback verbally and directly to staff, at resident and representative meetings and through surveys. Staff and management were able to explain how they support consumers to give feedback according to organisational policies and procedures.

Requirement 6(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives stated they are aware of advocacy and language services and other methods for raising and resolving complaints. Management explained the variety of methods they utilise to ensure consumers and/or representatives are aware of access to advocates, language services and external complaints mechanisms. The service provides advocacy, language services, including translation services and external complaints information in their admission pack, consumer handbook, and via a display of pamphlets and posters available at the entrance of the service and throughout other areas of the service.

Requirement 6(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives stated management are responsive to any matters they raise. The service has policies and procedures in place for managing feedback, complaints, and open disclosure. Feedback and complaints are recorded along with any action taken in response to the matters raised and this was evident from a review of the service’s complaints register. The process is overseen at the service by care managers, quality advisor and the chief executive officer, to ensure appropriate action and investigation is completed in response to complaints and that a process of open disclosure is used when things go wrong.

Staff could demonstrate an understanding of the term open disclosure and how it is used in relation to the feedback and complaints process.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives confirmed feedback and complaints are used to improve the quality of care and services. Management explained feedback and complaints are incorporated into the continuous improvement process, as feedback is recorded in the plan for continuous improvement. The process is overseen by the care managers, quality advisor and the chief executive officer and reported at all meetings.

# 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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

Requirement 7(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated an effective system in place to fill unexpected staff absences to ensure there is a full complement of staff on each shift. A base roster in line with the new care minute hours has been developed and has been implemented. Call bell responses are monitored by the organisation’s executive care manager and the service’s clinical care manager. They investigate and complete toolbox talks with staff for responses above 10 minutes.

The Assessment Team reviewed the rosters and the daily allocation sheets for the two weeks prior to the Assessment Contact, which indicated all shifts were filled utilising the service’s own and agency staff. Agency staff are scheduled to work when there is a large training program being conducted and large numbers of staff have been rostered onto the training.

Requirement 7(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated effective systems are in place to ensure the workforce is qualified and competent to perform their roles. Staff confirmed they have been provided with training and have access to information to ensure they are able to care for consumers safely and appropriately. Consumers and/or representatives were satisfied that staff are meeting the needs of consumers and were satisfied that staff are trained and competent to deliver the care and services they require.

The service monitors staff competency and training completion, as well as observe staff practices to ensure staff are effectively performing their roles. All staff are required to complete annual skills competency assessment for hand hygiene, personal protective equipment, and manual handling and are all rostered to attend a three-day mandatory training course covering a large range of topics.

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

New staff participate in a comprehensive orientation program and are supported with a minimum of three or four buddy shifts, or more if needed, depending on experience. Buddy shifts assist new staff members to get to know the consumers, and the processes and procedures needed to complete their role. Staff confirmed they have participated in training provided at the service, and that they have the resources and equipment they need to deliver appropriate care to consumers.

The service employs a full-time human resource and learning development coordinator to develop and manage the training program. The ongoing training program for staff include annual mandatory training, additional training in response to identified needs, training by external trainers, and on the job training.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated there is a formal process in place to review staff performance. All staff participate in an initial performance appraisal during their probationary period and then on the anniversary of their employment. The management team stated staff performance is also reviewed using consumer, representative and staff feedback, investigation of incidents, review of clinical data, staff meetings, and observations by senior staff. The people culture team monitor when staff performance appraisals are due, and a notification and reminder is sent the management team to ensure timely completion of the appraisals.

# 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Requirement 8(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated that consumers are engaged in the development, delivery and evaluation of care and serves and are supported in that engagement. The organisation is utilising questions from the consumer experience questionnaire to seek more in-depth feedback from consumers and/or representatives regarding service provision.

In May 2023, the management team held initial discussions with consumers and/or representatives in relation to the organisation’s strategic plan for 2023-2026. Consumers and/or representatives were invited to be part of a consumer advisory committee. This process includes obtaining expressions of interest from consumers regarding their interest in participating in the advisory committee, creating a direct path from resident meetings to the board, and a board member to attend the resident meeting to receive feedback directly from the consumers and representatives.

Requirement 8(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has systems in place to monitor service provision through conducting a program of audits and the monitoring of various clinical indicators, including those required under the national aged care mandatory quality indicator program. The organisation also uses an external benchmarking audit program to conduct routine audits across a range of clinical matters and those related to monitoring service provision against the Quality Standards.

Reports from various committees including the care governance committee, finance and investment committee, nomination and governance committee are provided to the board for review. The board is provided with detailed information to enable them to monitor actions being taken by the management team.

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has information systems to ensure staff have access to the information they need. There are communication processes for staff which include the electronic clinical documentation system and handover at each shift.

Management advised that opportunities for improvement are continuing to be obtained through surveys, feedback forms, complaints, feedback through various meetings, issues arising through the incident management system, data from the clinical indicators, audit results and changes in legislation. The organisation is also utilising the consumer experience questions in the consumer meetings to seek further feedback from consumers.

The quality advisor stated there is ongoing review of the continuous improvement plan and that evaluation of improvements are being undertaken to monitor their effectiveness.

The organisation has systems in place for financial management and will consider consumer care needs in relation to expenditure. Reports on expenditure and financial matters are referred to the board, and guidelines are in place for delegates regarding expenditure.

Information is provided to the board on staffing, including reporting on the recruitment and termination of staff across both services within the organisation. Monitoring the provision of care minutes and registered nurse minutes to comply with the workforce requirements will continue as a routine report to the board.

The chief executive officer advised that the organisation has memberships with two peak aged care industry bodies who provide regular updates and information on legislative changes. Information is received through updates from various government departments, such as state and federal health departments. Information is discussed at board meetings, and a register of key legislative dates is maintained to track the completion of various requirements.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has developed an organisational risk register which is reviewed and discussed as part of the board meeting. The chief executive officer advised that there will be further enhancements to the risk management process as part of the introduction of a new computerised management system.

The organisation has policies in relation to person-centred care which promote consumers being able to live the best life they can through maintaining a sense of control over care provision and staff respecting individual preferences.

The organisation has an incident management system. Management advised there was greater analysis of incidents to determine if there were any contributing factors or if consumers required referral to specialist services such as Dementia Services Australia. Information is referred to the board for further review when required.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The chief executive officer advised that information in relation to restrictive practice, complaints and infection rates are discussed at the board meetings. Queries from the board are referred back to the relevant staff for further action. The organisation has a clinical governance framework in place and staff demonstrated a clear understanding in regard to antimicrobial stewardship, restrictive practices, and open disclosure. Education on updated policies with regard to antimicrobial stewardship, open disclosure and restrictive practices has been provided to relevant staff.

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)