Performance

Report

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| Name of service: | Alkira Lodge |
| Service address: | 2A Bushland Drive TAREE NSW 2430 |
| Commission ID: | 0165 |
| Approved provider: | Bushland Health Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 July 2023 |
| Performance report date: | 10 August 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 Alkira Lodge (**the service**) has been prepared by K. Reed, 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 09 August 2023
* the Performance report completed 09 August 2022, following the Site audit 21-23 June 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **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

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.

* The use of restrictive practices must be in accordance with legislative requirements including authorisation and consent.

# 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. | Non-compliant |

Findings

The service was not demonstrating clinical and personal care delivery was best practice to optimise each consumer’s health and well-being in relation to authorisation and consent for chemical and environmental restraint. While consumers and representatives expressed satisfaction with the personal and clinical care provided to consumers, documentation does not support the legislative requirements in relation to restrictive practices.

The service failed to demonstrate adequate evidence of identifying, assessing, managing, and evaluating consumers' use of psychotropic medications and identifying chemical restrictive practices. The care documentation of nine consumers prescribed psychotropic medication, identifying nine consumers received chemical restraint without assessment, consent, and reviews documented.

Consumers were identified at the Site audit conducted 21 to 23 June 2022, to be environmentally restrained without consent. Of the seven previously identified consumers, three consumers were still identified without appropriate consent by the Assessment Team on 18 July 2023.

The Approved provider in its response to the Assessment contact-site report has stated the psychotropic medication register is now up to date for each consumer. Action is underway to obtain consent from medical officers and consumer representatives for restrictive practices relating to chemical restraint. The action plan submitted by the Approved provider indicates this action will be completed in September 2023. Relating to the three consumers who were subject to environmental restraint, the action plan indicates one consumer has capacity to make their own decisions and wishes to reside in the secure needs unit, and the service is reapplying to the Guardianship Board for consent for the other two consumers. This action has a completion date of October 2023.

While I acknowledge the actions taken by the Approved provider to address deficits in relation to restrictive practices, I also note these actions are yet to be completed and therefore it is my decision this Requirement remains Non-complaint. I am comfortable that consumers are receiving personal and clinical care to suit their individual preferences.

# Standard 6

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

Findings

Consumers and representatives confirmed if they provided feedback or made a complaint the service would listen to their feedback and use it to improve the services and care provided. Consumers provided examples of issues relating to missing clothing, which was recorded in meeting minutes, the complaints register and consumer newsletter. Consumers were satisfied with the handling of the complaint and the improvements made including the purchase of a labelling machine.

Actions have been taken to address deficits in this Requirement identified at the Site audit conducted 21 to 23 June 2022, actions have included:

A representative experience survey conducted in January 2023 indicated an 80% satisfaction rate to timely response to feedback and complaints. A consumer survey was undertaken in March 2023 in relation to consumer satisfaction to the service’s response and follow up to their concerns. The majority of respondents agreed that staff followed up their concerns.

Consumer meeting minutes noted issues and feedback raised by consumers was captured in the feedback register with the investigation, actions undertaken to resolve the issue and communication with the complainant.

The feedback register for January to June 2023 noted feedback from consumers and representatives was added to the feedback register including closing actions taken and communication recorded.

Management confirmed complaints were added to the feedback register and the Chief executive officer reviewed the register with relevant managers to monitor progress and outcomes. If there was an issue identified that was a potential risk this was included in reports provided to Board meetings.

Based on the feedback from consumers and representatives in relation to their satisfaction of complaints and feedback review and the evidence of improvements taken following complaints, it is my decision this Requirement is now 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. | Compliant |

Findings

The Assessment contact-site report contains information that information management systems were not effective to ensure staff had consistent and timely access to policies and procedures on legislative requirements for the delivery of quality care and services. The report also stated the service had an effective electronic care management system in place to assist staff in developing and maintaining care management plans.

Staff provided feedback they were unclear where to access policies and procedures in relation to legislative requirements. Information was recorded the April staff survey noted responses that policies and procedures were difficult to find.

The Approved provider has refuted this information and in its response to the Assessment contact-site report stated 85 members of staff participated in the staff survey and two comments were raised in relation to policies and procedures. The Approved provider submitted an employee satisfaction survey which noted over 80% of staff felt policies and procedures are easy to understand and are accessible. The action plan submitted by the Approved provider as part of its response has an action item that staff will be informed at meeting and via electronic communication where to access the Policy and procedure manual.

I do not consider deficits in staff knowledge of the location of policies and procedures indicates an ineffective information management system.

The Assessment contact-site report has information relating to the service’s plan for continuous improvement and the lack of updated actions since September 2022. The Approved provider refuted this information and submitted as part of its response the plan for continuous improvement for 2023, which the Approved provider states was provided at the time of the Assessment contact-site.

I therefore do not consider the organisation to have deficits in continuous improvement.

While I acknowledge documentation did not support the legislative requirements in relation to restrictive practices, I have also considered information recorded that the service monitored legislative changes through weekly bulletins as a member of external industry associations and subscribing to regular media releases and relevant policies and procedures were updated by the Quality Manager and submitted to the Board for approval prior to circulating to staff via email and discussed at staff meetings.

The organisation had effective workforce and financial governance systems. The organisation was also able to evidence an effective feedback and complaints process as evidenced by a return to Compliance in Requirement 6 3) d).

It is my decision that deficits in the authorisation of chemical and environmental restraint have been considered in Requirement 3 3) a), and these deficits do not convince me the service does not have effective organisational governance. It is my decision this Requirement is 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)