

**Performance Report**

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| Name: | Barrington Lodge |
| Commission ID: | 8031 |
| Address: | 120 Swanston Street, NEW TOWN, Tasmania, 7008 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 19 November 2024 to 20 November 2024 |
| Performance report date: | 23 December 2024 |
| Service included in this assessment: | Provider: 1671 The Salvation Army (Tasmania) Property Trust Service: 5004 Barrington Lodge |

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 Barrington Lodge (**the service**) has been prepared by Louise Malone, 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) was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others
* the provider’s response to the assessment team’s report received 15 December 2024

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Applicable as not all Requirements assessed** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **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 2(3)(e) – assessment and care planning reviews are comprehensive and assess the effectiveness of care and services
* Requirement 3(3)(a) – clinical and personal care delivered is best practice, tailored to the consumer’s needs and preferences including support for hygiene, wound care and the use of restrictive practices
* Requirement 3(3)(b) – high-impact, high-prevalence risks are effectively managed including medication management, wound care and catheter management
* Requirement 6(3)(c) – consumer and representative feedback is appropriately documented and actions are taken to resolve complaints
* Requirement 6(3)(d) – feedback is effectively reviewed and used to identify opportunities for improvement to, and taken actions to, improve, care and services
* Requirement 7(3)(c) – the workforce is competent within their defined roles and responsibilities and have the necessary skills and qualifications to perform their roles
* Requirement 7(3)(d) – training delivered to the workforce enables delivery of outcomes required by the Quality Standards and that training addresses the learning needs of the workforce
* Requirement 8(3)(c) – effective organisation wide governance, specifically in the areas of continuous improvement and the management of feedback and complaints
* Requirement 8(3)(d) – risks, including high-impact, high-prevalence risks to consumer wellbeing are effectively identified, recorded, investigated and managed to minimise risks for all consumers
* Requirement 8(3)(e) – effective clinical governance, specifically in relation to the minimisation of restrictive practices.

# Standard 2

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| Ongoing assessment and planning with consumers |  |
| 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. | Not Compliant |

Findings

Requirement 2(3)(e):

The service was previously found non-compliant with Requirement 2(3)(e) as the service did not demonstrate consumer care reviews consistently occurred as per the service’s schedule, or following a change in the consumer’s condition. Improvement actions were implemented in response to the finding including processes to improve management oversight of adherence to schedules of reviews, audits of care review completion and staff education in clinical documentation.

During the Assessment Contact from 19 November 2024 to 20 November 2024 (the Assessment Contact), care documentation provided evidence of reviews of assessment and care planning occurring, however did not effectively consider the consumer’s holistic or current needs. Examples presented in the Assessment Contact report include evidence of a review of care occurring for a consumer experiencing falls to consider falls management and mobility, but not consider associated wound changes and reported pain. In another example, equipment and strategies in place to prevent falls were not reflected in the consumer’s assessment and care planning documentation and the evidence did not demonstrate a review of the effectiveness of these strategies since implementation.

The Assessment Team recommended this requirement as Not Met.

The provider submitted a response to the Assessment Contact report dated 15 December 2024 (the response) which provides evidence of action taken to review assessment and care planning documentation for the examples presented in the Assessment Contact report and plans to complete a comprehensive assessment and care planning review for all consumers.

I acknowledge the actions already taken, and plans for ongoing improvements to assessment and care planning reviews, however at the time of my decision, further time is required to implement and sustain the improvement actions. I find Requirement 2(3)(e) Not 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.
 | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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):

The service was previously found non-compliant with Requirement 3(3)(a) as the service did not demonstrate best practice, and tailored delivery of personal care and clinical care. Deficits in recognising signs of pressure injury and inaccuracies in wound identification were identified. Improvement actions were implemented in response. These included updating handover information with consumer’s personal care needs and preferences, staff education in wound management, and processes to improve clinical monitoring.

During the Assessment Contact, consumers and representatives provided feedback that clinical and personal care does not meet their needs, that care is not delivered at the required frequency, and that staff manual handling practices exacerbates the consumer’s pain. The Assessment Team found evidence of omitted wound care, incorrect wound classification and an example of wound deterioration. The service did not demonstrate that restrictive practices are appropriately identified; consumers prescribed medications ‘as required’ to manage changed behaviour were not identified as having a prescribed chemical restrictive practice, and equipment in place to prevent falls through limiting independent mobility was not identified as a mechanical restrictive practice. The Assessment Team found the service did not effectively consider the risk of restrictive practices for consumers who chose to lock their bedroom doors as no assessment of consumer independence in locking and unlocking the door had been undertaken. During the Assessment Contact a key to an individual consumer’s room was not readily available.

In the response, the provider acknowledges the findings in the Assessment Contact report and provides evidence of actions taken and planned to improve clinical and personal care delivery including consultation and review of personal and clinical care for consumers with identified deficits, review of inaccuracies in documentation, appointment of a medication consultant, staff education and evidence of individualised approaches to behaviour management and appropriate identification and consideration of risks in the use of restrictive practices.

The Assessment Team recommended Requirement 3(3)(a) as Not Met.

In coming to my decision, I have considered the impact on consumers when personal and clinical care does not meet their needs and am persuaded by the feedback from consumers and representatives in the Assessment Contact report about their dissatisfaction. I acknowledge the actions taken by the provider to date, and those in progress, and I acknowledge evidence of positive feedback from some consumers about the actions taken. However further time is required for improvements to be sustained and evaluated to ensure clinical and personal care delivered to each consumer aligns with best practice, and the consumer’s needs and preferences. I have found Requirement 3(3)(a) Not Compliant.

Requirement 3(3)(b):

The service was previously found non-compliant with Requirement 3(3)(b) due to ineffective management of high-impact, high-prevalence risks. These included falls, medication incidents and changed behaviours, and incidents were not being consistently documented, or reported to the Serious Incident Response Scheme (SIRS) appropriately. Improvement actions implemented in response to the findings included a review of all identified incidents and improvements to systems to capture and monitor incident data, and staff education about SIRS and managing changed behaviours.

During the Assessment Contact, the service demonstrated risks to consumer wellbeing were not effectively managed. Incidents adversely impacting consumers such as medication errors or catheter management errors had not been appropriately documented and the contributing risks not prevented. Consumers provided examples of poor staff practice with associated harm, including staff repetition of medication errors despite correction from the consumer.

The Assessment Team recommended this requirement as Not Met.

In the response, the provider acknowledges the findings in the Assessment Contact report and provides evidence of actions taken to address risks to consumers identified, document and report past incidents appropriately and educate staff on expectations of practice. However, I am persuaded by the examples in the Assessment Contact report which describe risks to consumers which were not effectively prevented, and incidents which had negative impact on consumer wellbeing. Further improvements are required in the service’s systems to identify and respond to high-impact, high-prevalence risks, and consistently document, investigate and respond to incidents. I find Requirement 3(3)(b) Not Compliant.

Requirement 3(3)(g):

The service was previously found non-compliant with Requirement 3(3)(g) as it did not demonstrate best practice antimicrobial stewardship. Improvement actions implemented in response to the finding included involving medical practitioners, improved monitoring of the use of antimicrobials and staff education.

During the Assessment Contact staff described how they apply best practice principles and non-medication strategies to prevent infections such as ensuring hygiene and hand washing, monitoring signs of infection, appropriate use of pathology and referral to a medical provider where appropriate. The service demonstrated effective monitoring and reduction in the use of antimicrobials.

The Assessment Team recommended Requirement 3(3)(g) as Met. I have considered the evidence and am satisfied it demonstrates infections risks are minimised through effective infection control practices and promotion of appropriate antimicrobial prescribing. I find Requirement 3(3)(g) Compliant.

# Standard 4

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| Services and supports for daily living |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:1. participate in their community within and outside the organisation’s service environment; and
2. have social and personal relationships; and
3. do the things of interest to them.
 | Compliant |

Findings

Requirement 4(3)(c):

The service was previously found non-compliant with Requirement 4(3)(c) as consumers did not feel supported to do the things of interest to them and had limited opportunities for participation in the external community. The service implemented improvement actions including conducting a consumer survey and using the feedback to plan the lifestyle program, and increasing the frequency of community bus trips.

During the Assessment Contact, consumers and representatives provided positive feedback about the regular bus outings and the way consumers are supported to maintain important social relationships. Information about the consumers’ background, interests and hobbies was found to be documented in consumer care files, and the service demonstrated ways consumer feedback is sought, to understand consumers’ areas of interest and plan the schedule of activities.

The provider’s response includes further information related to ongoing evaluation of the lifestyle program, recruitment of a lifestyle coordinator, and plans to address consumer feedback about variety of activities

The Assessment Team recommended Requirement 4(3)(c) as Met. I have considered the evidence and am satisfied it demonstrates Requirement 4(3)(c) is 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement 6(3)(c):

The service was previously found non-compliant with Requirement 6(3)(c) as it was not able to demonstrate that consumers’ feedback and complaints were effectively recorded and addressed, and staff did not practice open disclosure. Improvement actions were implemented in response including the delivery or training on feedback and complaints processes, open disclosure training, and a monthly analysis of documented feedback and complaints.

During the Assessment Contact, consumers and representatives expressed dissatisfaction with the actions taken in response to complaints about staff competence, and personal and clinical care delivery. The Assessment Team found some complaints raised by consumers were not documented or addressed. Others had been documented and closed without resolution, and the issues described by consumers in these complaints were ongoing.

The Assessment Team recommended this requirement as Not Met.

In the response, the provider acknowledges the findings presented in the Assessment Contact report and provides evidence of actions taken to rectify the issues for the consumers identified. The service provides evidence of engagement with consumers and the service’s advocacy manager to seek resolution to issues raised about clinical and personal care. It includes evidence that feedback has been appropriately documented, as well as review of relevant policies, and delivery of training to staff about feedback and complaints management processes.

The provider submits evidence which corrects some information in the Assessment Contact report related to actions taken at the time of a complaint provided by one consumer. The response identifies this complaint was closed some weeks later, contrary to evidence in the Assessment Team report. I accept the provider’s evidence and have considered this in my decision.

I acknowledge the provider’s actions to date, but further time is required to ensure a robust system of feedback and complaints management is embedded and sustained to ensure consumers’ and representatives’ concerns are appropriately captured and responded to. I am persuaded by the dissatisfaction expressed by consumers and representatives and the risks that without a robust system, other concerns may remain unresolved. I find Requirement 6(3)(c) Not Compliant.

Requirement 6(3)(d):

The service was previously found non-compliant with Requirement 6(3)(d) as the service did not demonstrate feedback and complaints are used to inform improvements to care and service delivery. In response to the finding, improvement actions were implemented including a quarterly consumer survey and regular review of feedback and complaints by various levels of management.

During the Assessment Contact, consumers and representatives provided feedback that the service is not responsive to their complaints and could not identify improvement actions taken to address their concerns with staffing, and personal and clinical care delivery. The Assessment Team found that these concerns were not evidenced in the feedback and complaints register, and the service’s plan for continuous improvement (PCI) did not identify improvement opportunities in these areas as a result of consumer feedback. The service’s data showed a decrease in complaints in the months prior to the Assessment Contact and high consumer satisfaction rate. The Assessment Team found this did not reflect evidence of consumer dissatisfaction found during the Assessment Contact.

The Assessment Team recommended this requirement as Not Met.

In the response, the provider submits evidence of how the service will use the feedback identified in the Assessment Contact report to inform service wide improvements to personal and clinical care. It describes ongoing plans and processes to document and review feedback at management level and processes to evaluate and monitor compliance with policies and procedures through regular internal audits. The provider also described broader ongoing actions to increase consumer awareness about the feedback and complaints process and plans to deliver staff training in complaints management and escalation processes.

I have considered the evidence and acknowledge the actions taken to date by the provider, however improvements must be further embedded and sustained. I find Requirement 6(3)(d) Not Compliant.

# Standard 7

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| Human resources |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not 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)(c):

The service was previously found non-compliant with Requirement 7(3)(c) as effective systems to ensure the workforce has the required qualifications and knowledge to perform their roles was not demonstrated. The service implemented actions in response to the findings including recirculating position descriptions and policies and procedures to all staff, and ensuring this information is accessible.

During the Assessment Contact, consumers and representatives provided feedback about their dissatisfaction with staffing levels, the competence of agency staff, and described negative impacts as a result of staff practice. A consumer described staff practicing outside their scope leading to adverse impacts on the consumer. It was found this incident had not been documented by staff or appropriately investigated. Evidence in the Assessment Contact report indicates deficits in the delivery of wound care, medication administration, the identification and minimisation of restrictive practices and documentation of feedback and incidents. The service did not demonstrate evidence of systems to monitor staff qualifications, and criminal history checks,

The Assessment Team recommended this requirement as Not Met.

In the response, the provider submits evidence and explanation of how the service is monitoring staffing numbers, skill mix and competence level, provide details of the type of training provided, and a description of the service’s expectations for documentation and the management of incidents. The provider also submits evidence which directly addresses the example in the Assessment Contact report and demonstrates actions taken for the consumer’s well-being and to address staff practice.

The examples presented in the Assessment Contact report related to staff competence demonstrate impact on consumers, and although the provider’s evidence satisfies me of rectifying actions taken since the Assessment Contact for the consumer examples, I am not satisfied this demonstrates an effective system to ensure staff have appropriate knowledge and skills, and that it is applied in practice. I believe further time is required to implement and sustain systemic improvement actions. I find Requirement 7(3)(c) Not Compliant.

Requirement 7(3)(d):

This service was previously found non-compliant with requirement 7(3)(d) as the service did not demonstrate how staff training needs are effectively identified and supported, and staff completion mandatory training was not up to date. The service implemented improvement actions including review of training modules delivered to address key areas of care and service delivery, providing staff with time and resources to complete training, and systems to monitor staff participation and broader changes in the service’s model of care delivery.

During the Assessment Contact, consumers and representatives provided feedback that some staff are not knowledgeable, practice poor manual handling, or do not follow the consumer’s personal or clinical care plan. The Assessment Team found a proportion of staff were yet to complete their mandatory modules, and management identified recent challenges due to recent changes in the service’s model of care being implemented.

The Assessment Team recommended this requirement as Not Met.

In the response, the provider corrected some information in the Assessment Contact report; the Assessment Team found staff completion rates of mandatory training to be 72%, the provider submits evidence that it was 82%. I accept the provider’s correction. The response includes evidence related to delivery of mandated care minutes, and details of the next 12 months learning and development plan key focus areas.

I have considered the evidence and find that further time is required to implement and evaluate the improvement actions and ensure that the workforce is trained, equipped and supported to deliver outcomes required by the Quality Standards. I find Requirement 7(3)(d) Not Compliant.

Requirement 7(3)(e):

The service was previously found non-compliant with Requirement 7(3)(e) as regularly assessment, monitoring, and review of the performance of the workforce was not demonstrated. The service implemented improvement actions in response including an electronic system to monitor compliance with the scheduled workforce performance reviews.

At the Assessment Contact, management and staff confirmed the service has a probationary and ongoing performance review system. Performance review alerts are generated by the electronic system with reviews conducted at regular intervals for new staff, and annually for all staff. Documentation demonstrated, and staff confirmed, performance reviews are completed and provide opportunities to discuss learning and development needs.

Although the provider’s response does not address Requirement 7(3)(e) specifically, it includes information about actions taken to address staff performance in relation to issues with clinical cand personal care described in the Assessment Contact report.

The Assessment Team recommended this Requirement as Met. I have considered the evidence in both the Assessment Contact report and the provider’s response, and I am satisfied a system for workforce performance review is in place and the service is taking actions to identify staff performance issues and learning and development needs.

I find Requirement 7(3)(e) 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 |
| 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.
 | Not 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.
 | Not Compliant |

**Findings**

Requirement 8(3)(c):

The service was previously found non-compliant with Requirement 8(3)(c) as feedback and complaints were not accurately captured and reported to the governing body. In response to the finding the service implemented improvement actions including new management, staff education, and improvements to processes to support management oversight of feedback and complaints.

During the Assessment Contact, the Assessment Team found the service did not demonstrate effective organisation wide systems for management of feedback and complaints, continuous improvement and workforce governance. While the service has a range of methods for consumers and representatives to provide feedback, it did not demonstrate accurate and consistent capture of consumer feedback and complaints, therefore was not accurate in communication with the governing, and feedback was not being effectively used to inform continuous improvement actions. At the time of the Assessment Contact, the service had recently completed an internal audit which confirmed these findings.

The Assessment Team recommended Requirement 8(3)(d) as Not Met.

In the response, the provider confirms the various methods of capturing feedback and acknowledges that improvements can be made to the way feedback informs continuous improvement actions. The provider described planned changes to feedback and complaints management, and to the leadership structure and to service culture. The provider’s response includes information that internal audits and reviews have informed the service’s PCI, and the provider submits details related to how they will improve workforce governance and continuous improvement.

I acknowledge the provider’s response, and the relevance of actions planned however, further time is required to implement changes to organisation wide systems of governance. I find Requirement 8(3)(c) Not Compliant.

Requirement 8(3)(d):

The service was previously found non-compliant with Requirement 8(3)(d) as it did not demonstrate risk management systems were effective in preventing and managing high-impact, high-prevalence risks. In response to the finding, a range of improvement actions were implemented including implementation of a complex health care register to identify consumers with high-impact, high-prevalence risks, and daily review of all clinical incidents to oversee appropriate investigation and response.

During the Assessment Contact, the service did not demonstrate effective management oversight of high-impact, high-prevalence risks including the management of wounds and the use of restrictive practices. Through review of documentation and staff and consumer interviews, the Assessment Team found evidence of inaccuracies in wound classification and care that did not align with best practice. A review of the SIRS register provided evidence of reporting in line with mandatory obligations for those documented, but examples identified the use of medication or equipment as a restrictive practice in place but not identified as such and subsequently not reported as an inappropriate use of restrictive practice. The Assessment Team found the service has policies and procedures which support the consumer’s right to engage in choices which involve risk and live the life they wish.

The Assessment Team recommended Requirement 8(3)(d) as Not Met.

In the response the provider described actions to educate all staff, including the management team, on SIRS reporting obligations and restrictive practice identification. The provider’s response described broad organisational changes with consideration of management oversight and changes to culture and practices to improve risk management. I note the provider’s evidence corrects some information in the Assessment Team report; the Assessment Team found that a consumer reporting missed occasions of care had not been reported as a SIRS incident. However, evidence submitted by the provider demonstrates a SIRS report was submitted at the time of the incident. I have considered this evidence in coming to my decision.

I acknowledge the provider’s planned organisation wide actions to address risk management systemically, but further time is required to implement and sustain this improvement. I find Requirement 8(3)(d) Not Compliant.

Requirement 8(3)(e):

The service was previously found non-compliant with Requirement 8(3)(e) as monitoring of antimicrobial use medications was not best practice and staff were not familiar with open disclosure or how it related to their role and responsibilities. Improvement actions were implemented in response to the finding including oversight by Medication Advisory Committee (MAC) and clinical governance committee of antimicrobial prescribing and other areas of clinical practice.

During the Assessment Contact, improvements in antimicrobial stewardship were found to have been effective, and staff were knowledgeable on the principles of open disclosure. However, the service did not demonstrate effective clinical governance to minimising the use of restrictive practices, and some forms of restrictive practices in use were not recognised. The chemical restrictive practice register did not document all consumer with ‘as required’ psychotropic medication prescriptions used to manage changed behaviours and consumers who chose to lock their bedroom doors had not been assessed as to whether they could do so independently. The potential for these practices to be environmentally restrictive practice or seclusion was not adequately considered.

The Assessment Team recommended Requirement 8(3)(e) Not Met.

The response submitted by the provider acknowledges the positive findings in relation to antimicrobial stewardship and the findings related to unrecognised use of restrictive practices. The response describes plans to review consumers and provide coaching and mentoring to clinical staff, and this is to be overseen by the service’s Nurse Advisor. The service has also reviewed and updated the psychotropic medication, and restrictive practices register to ensure that the information is consistent and accurate. The provider submits evidence that SIRS reports have been completed where appropriate in relation to the use of restrictive practices.

I acknowledge the actions taken to date by the provider and plans to further implement and sustain the improvements. I find further time is required for the service to fully implement and evaluate the improvements in correct identification and best practice approaches to minimising the use of restrictive practices. I find Requirement 8(3)(e) Not 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)