Performance

Report

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| Name of service: | Barrington Lodge |
| Service address: | 120 Swanston Street NEW TOWN TAS 7008 |
| Commission ID: | 8031 |
| Approved provider: | The Salvation Army (Tasmania) Property Trust |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 June 2023 to 14 June 2023 |
| Performance report date: | 28 June 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 Barrington Lodge (**the service**) has been prepared by N Eastwood, 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.

# 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 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 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)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | 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

The service was previously found non-compliant with requirement’s 2(3)(a), 2(3)(b), 2(3)(d), 2(3)(e) following a Site Audit performed between 22 March 2022 to 25 March 2022. At the time of the Site Audit the service was unable to demonstrate:

* assessment and care planning documents were always considered, informed the delivery of safe and effective care for individual consumers, or that staff completed care assessment and planning in line with the service’s clinical care assessments, policies, and procedures,
* assessment and care planning identified and addressed consumer’s current needs, goals, and preferences including advance care planning and end-of-life planning,
* consumers and representatives had received a care plan or been advised how they may access care plans,
* consumer care is always reviewed or that care plans reflect changes to consumer care needs as they occur

The service has implemented several effective actions in response to the non-compliance previously identified including staff education, introduction of return from hospital forms and electronic systems, review of respite admission procedures, end of life processes, routine review of care plans and supporting audits and communication at relevant meetings and updates.

With regard to requirement 2(3)(a) consumers and representatives confirm that staff assess and mostly provide safe consumer care, as well as being notified about any incidents or changes to care. The Assessment Team noted one consumer would like to be repositioned more frequenetly and a representative indicated repositioning could be improved. Staff could describe the process for conducting assessments including identifying risk and care documentation reviewed by the Assessment Team reflected current assessments and information in care plans, as well as updated following a change to their health status or an incident.

With regard to requirement 2(3)(b) consumers and representatives confirmed that end-of-life care including advanced care directives, had been discussed with them and that consumer needs are mostly being addressed. The Assessment Team noted concerns raised by some representatives that staff did not always assist their family members with meals and drinks. Clinical staff described how they involve consumers and representatives in end-of-life discussions and consult with them regarding assessment and planning. Staff were able to detail the needs and preferences of sampled consumers and consumer files reflected current consumer information. The Assessment Team reviewd care files and the handover sheet which included summaries and prompts for staff related to consumer preferences and care needs.

With regard to requirement 2(3)(d) consumers and representatives confirmed they have been offered and/or received a care plan and as consumer care needs change, they are informed. Nursing staff could describe how they involve consumers and representatives in discussions about the changes to consumer care outcomes and how they encourage access to care plans. The service has a policy on assessment and planning to guide staff in assessing and planning consumer needs, sharing this information with the consumer and representative, and providing access to care plans. The Assessment Team reviewed consumer files which demonstrated the sharing of information with consumers and representatives and that care plans had been offered.

With regard to requirement 2(3)(e) the Assessment Team reviewed the services management of a consumer with a change in care needs. The consumer confirmed they had been been included in discussions regarding the changes to care requirements and the updates to care planning requirements. The Assessment Team reviewed care file documentation which demonstrated contemporaneous review and updates to care planning and care delivery as well as contact and inclusion of the representative.

As a result, and with consideration to the implemented actions and available information I find these requirements now 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)(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 |

Findings

The service was previously found non-compliant with requirement’s 3(3)(a), 3(3)(b), 3(3)(e) following a Site Audit performed between 22 March 2022 to 25 March 2022. At the time of the Site Audit the service was unable to demonstrate:

* consumers wounds were being managed to optimise consumer health and well-being according to best practice,
* consumers were effectively assessed, monitored, and reviewed if they were subjected to any form of restrictive practice,
* consumer care and services plans are up to date, and that the information from multiple sources was being communicated effectively to relevant members of the workforce.

The service has implemented several effective actions in response to the non-compliance previously identified including staff training and competency assessments, workforce communication improvements, introduction of documentation to ensure continuity of care, audit’s of practise, review of policies and procedures.

With regard to requirement 3(3)(a) representatives confirmed their satisfaction that staff are competent and providing good care to their loved ones. The Assessment Team observed, and staff confirmed education and training had been provided related to wound management and associated documentation. Management confirmed they are monitoring all active wound charts weekly, to ensure wound care is not missed and each wound is reviewed on the correct date. The Assessment Team noted that the wound charts did not demonstrate a consistent approach to photographing, measuring, and description of wounds. The Assessment Team reviewed education evaluations following pressure injury and skin tear training with competency assessments reviewed and signed by the general manager.

With regard to requirement 3(3)(b) consumers and representatives confirmed an improvement in management of consumers with changed behaviours. Consumers and representatives reported specialised nursing care needs are well managed and staff confirmed they had attended extensive education and training sessions on a variety of clinical care assessments and management education and training. Staff described behaviour management strategies in place to manage specific consumer needs, however the Assessment Team noted that use of as required medication was not always adequately documented. Staff confirmed attending training in restrictive practices and could describe mechanical and environmental restraints as well as the reasons consumers were subject to these practices The Assessment Team reviewed consumer care documentation confirming care plans are individualised and contained information to guide staff in specialised clinical care provision. Additional high-impact or high-prevalence risks associated with the care of each consumer were also noted to be adequately documented and managed.

With regard to requirement 3(3)(e) representatives confirmed the service keeps them informed about their loved one’s condition and clinical care. Management advised and staff confirmed education and training both face-to-face and online has been provided to clinical and care staff. The Assessment Team observed a clinical handover with commencing staff provided with an update on each consumer including any incidents that had occurred and any changes in a consumer conditions. A review of care plan documentatiom confirmed assessments are commenced following entry to the service, as part of the monthly ‘customer of the day’ review or 3-monthly care plan review and on return to the service after a hospital visit.

As a result, and with consideration to the implemented actions and available information I find these requirements now compliant.

# Standard 8

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| Organisational governance | |  |
| 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

The service was previously found non-compliant with requirement’s 8(3)(d), 8(3)(e) following a Site Audit performed between 22 March 2022 to 25 March 2022. At the time of the Site Audit the service was unable to demonstrate:

* managing high-impact or high-prevalence risks associated with the care of consumers,
* a system in place to ensure consumers subjected to restrictive practices are being effectively assessed, monitored for side effects, and reviewed regularly for effectiveness according to legislative requirements.

The service has implemented several effective actions in response to the non-compliance previously identified including several toolbox education sessions in relation to identified high-impact or high-prevalence risks such as skin integrity, oxygen therapy, wound management, admissions, transfer, return from hospital, care planning, and end-of-life care.

With regard to requirement 8(3)(d) the service has implemented a high-impact, high-prevalence risk register which is reviewed at a service and organisation level. The review is used to evaluate risks, identify trends and plan for remediating actions. Management discussed a number of initiatives used to monitor, review, and manage these risks including daily management huddles (10 at 10), high-impact, high-prevalence risk register, complex health care needs register, monthly clinical governance meetings, and regular audits. The Assessment Team noted the improvement in trends related to pressure injuries, however also noted room for improvement in consistent wound management documentation.

With regard to requirement 8(3)(e) the service has implemented a complex care needs register. The register includes a breakdown of all types of restrictive practices, details of consumers subject to restrictive practices and the reasons for them, review dates, authorisation, and whether a behaviour support plan is in place. The service has implemented a chemical restraint register that details consumers’ medications, indications, and diagnoses as well as restrictive practice authorisation forms and relevant staff education. The Assessment Team noted that while documentation had been implemented not all documents had been completed, management confirmed that they were waiting for the return of completed documents from representatives and medical officer attendance to complete outstanding documentation. The Assessment Team reviewed medical advisory committee meeting minutes noting the inclusion of scheduled drugs, auditing, psychotropic medications, review and reporting as a standing agenda item.

As a result, and with consideration to the implemented actions and available information I find these requirements now 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)