Performance

Report

**1800 951 822**

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| Name of service: | Cooinda Lodge Nursing Home |
| Service address: | 41 Landsborough Street WARRAGUL VIC 3820 |
| Commission ID: | 3473 |
| Approved provider: | West Gippsland Healthcare Group |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 November 2022 |
| Performance report date: | 16 January 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 Cooinda Lodge Nursing Home (**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 - 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 15 December 2022
* the provider’s compliance history including its response and plan for continuous improvements to a site audit conducted in August 2021.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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)(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 found Non-compliant in Requirements 2(3)(a), 2(3)(d), 2(3)e, at the reaccreditation site audit conducted in August 2021. An assessment contact was conducted on 17 November 2022 to assess the service’s progress in returning to compliance in these requirements. The Assessment Team found Requirements 2(3)a and 2(3)e not met and 2(3)(d) met. I have come to a different view and consider Requirements 2(3)a and 2(3)e are Compliant.

In relation to Requirements 2(3)(a) and 2(3)(e) the Assessment Team found concerns with incomplete assessment and planning, the management of risk and planning and in particular the review of chemical restraint and behaviour management plans, medication management and administration for consumers reviewed. The Assessment Team also had concerns about the assessment, planning and review of clinical care needs and specific risks such as pain, falls and wound management for identified consumers. In relation to Requirement 2(3)d the Assessment Team were satisfied consumer information is communicated to consumers and where care and services are provided. Consumers and their representatives were satisfied with assessment and planning, communication of the outcomes of assessment and planning. They were also satisfied with the regular review of the delivery of care and services when consumers’ needs, goals and preferences change.

The response from the Approved Provider supplied further evidence, information and clarification about the Assessment Team’s findings. The response refuted the findings of not met by the Assessment Team for Requirements 2(3)(a) and 2(3)e. The response included examples of a comprehensive behaviour support plan, examples of regular consumer review by the general practitioner and clarifying information and further evidence mitigating concerns raised about the assessment and planning for the clinical care of reviewed consumers. The response also provided detailed notes, regular reviews and reports about consumers relating to psychotropic medication use and review, pain management, wound management, falls prevention and management and medication administration and review for identified consumers. The response provided detailed evidence demonstrating there was no evidence of any adverse impact on consumers that were reviewed by the Assessment Team.

I have considered the Assessment Team’s report and the response from the Approved Provider. I am persuaded by the further information in the documents and clarifying information supplied that the Approved Provider has demonstrated in the documentation supplied, the service’s improvement in assessment and planning including consideration of risks to consumers. It also demonstrated care and services are regularly reviewed for effectiveness. Based on the further information and documentary evidence supplied and the satisfaction of consumers and representatives with assessment, planning, communication about assessment outcomes, regular and systematic review of consumers and delivery of care and services, I have come to a different view to the Assessment Team. I find the service has demonstrated compliance with Requirements 2(3)(a), 2(3)(d), 2(3)e.

# 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)(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

The service was found Non-compliant in Requirements, 3(3)(a), 3(3)(g), at the reaccreditation site audit conducted in August 2021. An assessment contact was conducted on 17 November 2022 to assess the service’s progress in returning to compliance in these requirements. The Assessment Team found Requirement 3(3)a not met and 3(3)(g) met. I have come to a different view and consider Requirement 3(3)a is Compliant.

In relation to Requirement 3(3)(a), the Assessment Team noted consumers and representatives were satisfied consumers receive the care they need, and they are overall happy with the service. However, the Assessment Team found not all consumers are receiving appropriate and safe personal or clinical care, tailored to their needs and according to best practice. The Assessment Team found not all staff were able to describe best practice in relation to chemical restraint, wound and pain management. While consent for medication usage is obtained and documented, 3 of 4 consumer representatives said they had not had a detailed conversation about the risks of the recommended psychotropic medication.

The response from the Approved Provider supplied further evidence, information and clarification about the Assessment Team’s findings. The response refuted the findings of the Assessment Team for Requirement 3(3)(a). It highlighted a conflict in evidence about the service’s understanding and implementation of restrictive practice, pain and wound management and records and the Assessment Team’s findings. I acknowledge the further information and evidence supplied about 4 named consumers who were identified as not having completed records and documentation in relation to management of pain, falls and wound management substantiates that the management and records were in place at the time of the site audit and support compliance with Requirement 3(3)(a).

As a result, of concerns about whether representatives had been informed about the risks of recommended psychotropic medication, since the assessment the service has contacted all representatives and had a conversation about the psychotropic medication currently prescribed, consent and expectations about ongoing communication about medication usage. The service has updated data, records and consumer documentation. On this basis I agree with the Approved Provider that compliance with legislative requirements in relation to restrictive practice and the completion of individualised behaviour support plans for consumers receiving chemical restraint has been demonstrated.

In relation to 3(3)(g), the Assessment Team found the service was able to demonstrate preparedness in the event of an infectious outbreak. Evidence of monitoring, recording, collating and trending infections monthly was observed and is discussed in clinical meetings and the aged care governance committee attended by management, infection control and prevention representatives and allied health and quality and safety representatives. Consumers and representatives were satisfied with the service’s management of infection and the prescribing of antimicrobials.

I have considered the Assessment Team report and the response from the Approved Provider. I have come to a different view to the Assessment Team about compliance with Requirement 3(3)a. I am persuaded by the information provided in the response, as outlined above and am satisfied the Approved Provider has demonstrated it implements legislative requirements in relation to the use of restrictive practices. The Approved Provider has also demonstrated in the documentation supplied, including progress notes and consumer records that consumers are receiving appropriate and safe personal and clinical care, tailored to their needs and according to best practice including for falls, wounds and pain management and no adverse impact has been identified. I find that after consideration of the further information supplied in the response to the Assessment Team’s report the Approved Provider has demonstrated compliance with Requirement 3(3)a. Based on the Assessment Team’s report I find the service is also Compliant with Requirement 3(3)g.

# 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. | Compliant |

Findings

The service was found Non-compliant in Requirement 7(3)c at the reaccreditation site audit conducted in August 2021. An assessment contact was conducted on 17 November 2022 to assess the service’s progress in returning to compliance in these requirements. The Assessment Team found Requirement 7(3)c not met. I have come to a different view and consider the Requirement is Compliant.

The Assessment Team found not all staff were able to demonstrate consistent assessment of risks, care planning or clinical care delivery for some consumers or an understating of restrictive practices, or monitoring. I have come to a different view to the Assessment Team. My view of compliance is supported in alignment with Requirements 2(3)a and 3(3)a. I consider assessment of risks, care planning and tailored and effective clinical care delivery has been demonstrated by staff. Adverse impact on consumer wellbeing, and care has not been substantiated by the Assessment Team. I consider staff are competent and have the knowledge to effectively perform their roles.

The Approved Provider refuted the finding of not met and supplied further documentation and clarifying information demonstrating compliance including reviews of identified consumers, medication reports and reviews, reviews by external stakeholders and the general practitioner. The Approved Provider also contends that it is meeting the legislative requirements in relation to restrictive practice and in particular identifying, managing and reviewing chemical restraint. The documentation provided in response to the Assessment Team’s concerns supported compliance and I accept the service is implementing the legislative requirements for consumers and assessing and reviewing restrictive practice.

I also acknowledge the service’s commitment to contacting all representatives to discuss restrictive practice and medication usage and the training on the topic undertaken by all staff including staff relatively new to the service. Scheduled education was also undertaken on pain management, open disclosure, skin integrity and antimicrobial stewardship in the last 18 months. Further as indicated by the response I accept the Approved Provider’s submission that the Assessment Team report has not evidenced any negative impact on consumer well-being. Representatives said staff know how to do their job.

I have considered the Assessment Team’s report and findings and the response from the Approved Provider. Based on the information outlined above I am persuaded by the information supplied by the Approved Provider and consider the staff are competent and have the knowledge to effectively perform their roles. Targeted training has been completed by staff. I find the service is Compliant with Requirement 7(3)c.

# Standard 8

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| Organisational governance | |  |
| 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 found Non-compliant in Requirement 8(3)(e) at the reaccreditation site audit conducted in August 2021. An assessment contact was conducted on 17 November 2022 to assess the service’s progress in returning to compliance in these requirements. The Assessment Team found 8(3)e not met. I have come to a different view and consider the Requirement is Compliant.

The Assessment Team found the service was unable to always demonstrate effective clinical governance in relation to restrictive practices. It found although there is a clinical governance framework and policies in relation to minimising the use of restrictive practices, antimicrobial stewardship and open disclosure, staff knowledge and practice did not always demonstrate implementation of the policies and practices.

The response from the Approved Provider addressed the concerns raised and it has supplied information and clarification supporting Compliance. The Approved Provider has Board oversight and receives regular reports, data and trends about clinical care, infections complaints and regulatory follow up oversight with gaps identified and for follow up. Benchmarking occurs against similar services and Multidisciplinary team meetings have been initiated to analyse data and make recommendations in response to the data.

An Infection Prevention and Control Lead is in place, infection data is reviewed to ensure antibiotics are not prescribed unnecessarily. The response identified a misunderstanding about trending and managing specific infection. I accept a communication appears to have occurred in the exchange between the staff and the Assessment Team.

Education has been provided prior to the Assessment Contact and after it to ensure all staff are competent and have currency in knowledge about for example restrictive practices and open disclosure. Evidence of training records and documented communication with a consumer demonstrating open disclosure was supplied,

I have considered the Assessment Team’s report and findings and the response from the Approved Provider. I am persuaded by the information supplied by the Approved Provider and consider a clinical governance framework is in place and is being implemented and includes oversight, monitoring and review of clinical care. The Approved Provider has demonstrated its clinical governance framework addresses antimicrobial stewardship, minimising the use of restraint and open disclosure. I find the service is Compliant with Requirement 8(3)e.

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)