Performance

Report

**1800 951 822**

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| Name: | Flynn Lodge |
| Commission ID: | 6994 |
| Address: | 245 Stuart Highway, ALICE SPRINGS, Northern Territory, 0870 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 4 March 2024 to 5 March 2024 |
| Performance report date: | 16 April 2024 |
| Service included in this assessment: | Provider: 6871 Australian Regional and Remote Community Services Limited  Service: 4402 Flynn 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 Flynn Lodge (**the service**) has been prepared by T Wilson, 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) – 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 27 March 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Fully Assessed |
| **Standard 3** Personal care and clinical care | **Not Fully Assessed** |
| **Standard 7** Human resources | **Not Fully Assessed** |
| **Standard 8** Organisational governance | **Not Fully 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)(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

As not all Requirements have been assessed the rating for this Quality Standard is not applicable.

The service was found to be non-compliant in this Requirement in a site audit conducted in August 2023. A range of improvements were introduced to return to compliance which included but is not limited to, education, introduction of corporate orientation and buddy shifts and additions to staffing.

The service provided a response on the 27 March 2024 but did not refer to this Requirement.

Consumer and representatives confirmed the ongoing review of care and service plans, including when circumstances change, or incidents occur. Care documentation demonstrated consumers have been regularly reassessed and care plans updated following identified changes in line with the service's policies procedures. Clinical staff were knowledgeable of the care plan review process and confirmed reassessment of care and service needs following incidents or other changes in a resident's condition.

I agree with the assessment team the service does meet this Requirement. The service has completed continuous improvement and had given an undertaking to continue with making improvements to ensure they can maintain compliance with this Requirement.

It is for these reasons I find Requirement (3)(e) 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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

As not all Requirements have been assessed the rating for this Quality Standard is not applicable.

The service was found to be non-compliant in these Requirements in a site audit conducted in August 2023. A range of improvements were introduced to return to compliance which included but not limited to, education, review of documentation, projects, increased monitoring and improved communications methods.

The service provided a response on the 27 March 2024 but did not refer to these Requirements.

Consumers and representatives confirmed consumers receive personal and clinical care that is tailored to their needs and optimises their health well-being. Staff provided examples of how they provide safe and effective care and demonstrated how care and services for each consumer is tailored to their needs and preferences. Care documentation was individualised, with tailored strategies to meet the unique needs of each consumer. Observations of consumers indicated they were consistently well presented, wearing clean clothing and groomed well.

Consumers and representatives confirmed end of life care planning commences from admission if they want to develop a care plan around end of life. Consumers end of life needs and preferences are monitored and provided through assessment of their pain, agitation, and discomfort. Clinical staff were able to provide examples of care provided to consumers during the end-of-life stage of care.

Care documentation included detailed individualised personal and clinical care management plans and strategies based on assessed needs and discussions with the consumers. Staff confirmed they are informed of any changes to consumers’ condition and needs through their handover processes, alerts on their electronic management systems, progress notes and staff meetings.

I agree with the assessment team the service does meet these Requirements. The service has completed continuous improvement and had given an undertaking to continue with making improvements to ensure they can maintain compliance with these Requirements.

It is for these reasons I find Requirements (3)(a), (3)(c) and (3)(e) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

As not all Requirements have been assessed the rating for this Quality Standard is not applicable.

Whilst the service has made improvements with this Requirement following non-compliance identified on during a site audit completed in August 2023, the assessment team has recommend not met due to the service not being able to demonstrate that regular assessment, monitoring, and review of the performance of each member of the workplace takes place and staff saying they have not had a performance review in over a year. There are no schedules in place or reports detailing the percentages of staff with completed performance reviews provided to them.

The service responded on the 27 March 2024 stating that as the assessment team indicated in the report many staff are either agency or newly appointed workers who were required to complete specialised courses which meant their probation feedback was not due until after the visit. A schedule of performance reviews was provided with those that had already occurred and others that were scheduled close to the due date. Agency staff have weekly reviews with the clinical nurse manager but they do concede that a performance review schedule has not been maintained to the required standard.

I have considered both the assessment teams report and the providers response, and I find the service does meet this requirement. The assessment teams report states that while some staff have not completed a formal performance appraisal in over twelve months staff confirmed they meet regularly with management through meetings and one to one conversations. Additionally, conversations occur in relation to performance management concerns which are then placed in personnel files. The information from both sources tell me that although the formal performance appraisal process was behind staff have had their performance monitored through other means. I trust the service will continue on its journey of continuous improvement and embed the new processes in place to ensure the yearly performance appraisal is completed on time.

It is for these reasons I find Requirement (3)(e) complaint.

# 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

As not all Requirements have been assessed the rating for this Quality Standard is not applicable.

The service was found non-compliant following a site audit completed in August 2023. In response to the non-compliance the service completed continuous improvements which included but was not limited to, updated its meeting schedule and polices, completed training and introduced new procedure pathways and tools.

The assessment team recommended this requirement as compliant as the service could demonstrate they had an effective clinical governance framework in place. There were some deficits identified such as not maintaining a log of infections and not understanding environmental restraint but the assessment team was satisfied with the improvements provided to them during the visit that the deficits would be rectified.

The assessment team found the service has a clinical governance framework and supporting policies, procedures in place which outline the clinical structure and processes to support safety and quality of services when providing care and identifying and managing risks. All clinical information is reviewed at the Clinical Governance and Risk Committee meetings and discussed at weekly multi-site services managers meetings.

The service provided a response on the 27 March 2024 but did not refer to this Requirement.

I agree with the assessment team the service does meet this Requirement. The service has completed continuous improvement and had given an undertaking to continue with making improvements to ensure they can maintain compliance with this Requirement.

It is for these reasons I find Requirement (3)(e) 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)