Performance

Report

**1800 951 822**

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| Name: | Forest Lake Lodge |
| Commission ID: | 5339 |
| Address: | 12 Tewantin Way, Forest Lake, Queensland, 4078 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 18 April 2024 |
| Performance report date: | 15 May 2024 |
| Service included in this assessment: | Provider: 589 Lollies Management Pty Ltd  Service: 3693 Forest Lake 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 Forest Lake Lodge (**the service**) has been prepared by T Wurf, 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 on 3 May 2024, and
* the Performance Report dated 15 December 2023 following an assessment contact conducted on 8 November 2023, which found the service non-compliant with requirement 3(3)(a) of the Quality Standards.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements of the Quality Standard were 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 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 |

Findings

Having considered the Assessment Contact Report and approved provider’s response, I have decided this requirement is compliant.

I have made this decision based on the following analysis.

A Performance Report dated 15 December 2023 found the service non-compliant with this requirement following an assessment contact conducted on 8 November 2023. Non-compliance was based on deficiencies in the service’s management of and staff knowledge about, falls and restrictive practices (chemical and environmental).

The Assessment Contact Report for the assessment contact conducted on 18 April 2024 included evidence that the service had made improvements and remediated deficiencies in relation to falls management, however, identified ongoing deficiencies in the identification and management of chemical and environmental restraint. The Assessment Contact Report found this requirement not met.

The approved provider’s response to the Assessment Contact Report accepted the findings and provided information and evidence of actions taken to address deficiencies and improve the service’s practices around environmental and chemical restraint. I am satisfied those actions have been completed and have remediated the deficiencies.

Falls management

Based on evidence in the Assessment Contact Report, I am satisfied that the service implemented actions to address deficiencies and improve falls management. Actions included:

* Staff education on falls prevention and management.
* Audits of falls risk assessments. Audit results for January 2024 showed all falls risk assessments were reviewed and updated following falls.
* Reviewed consumers’ care documentation to ensure individualised falls risk and management strategies were documented, reviewed and implemented.
* Established a falls prevention committee that meets fortnightly to discuss strategies for consumers identified with frequent falls and/or high falls risk.

The Assessment Contact Report further identified:

* Consumers and representatives were satisfied with how the service manages and communicates with them about falls risk and following a fall.
* Consumers’ care documentation reflected assessment of mobility and falls risk, management of falls in accordance with the service’s falls management policy and falls prevention strategies in place.
* Staff knew consumers and strategies to manage falls risks. Registered staff understood the service’s falls management processes, including post-fall interventions.
* Falls are reviewed weekly and clinical reports are analysed/trended monthly. There has been a downward trend in falls at the service from November 2023 to March 2024.
* The service has policies, procedures, and flowcharts to guide staff in the management of falls.

Restrictive practices

The Assessment Contact Report identified that, following the finding of non-compliance, the service provided staff education on restrictive practices and reviewed consumers’ care documentation to ensure it was consistent with legislative requirements for use of restrictive practices. For those consumers the service had identified as subject to a restrictive practice, authorisations, informed consent, risk assessments and behaviour support plans were in place and reviewed regularly.

However, the service had failed to identify some consumers that were subject to chemical restraint and environmental restraint, and therefore had not managed these in line with legislative requirements for the use of restrictive practices.

*Chemical restraint*

Whilst the service had appropriately identified and managed three consumers subject to chemical restraint, the service had not identified another three consumers who were prescribed psychotropic medications to influence behaviour as being subject to chemical restraint. These consumers had behavioural support plans in place that directed staff to use the medication as a last resort for management of changed behaviours, and one consumer had not received the medication in the past four months.

The approved provider’s response to the Assessment Contact Report included:

* Clarifying information that for two of the three consumers, relevant authorisation, consent and documentation for use of the medication had been in place but were removed on 12 April 2024 in error following a medical review.
* Evidence that relevant documentation had been put in place to support the use of chemical restraint for those consumers and behaviour support plans updated.
* Information about a new process of weekly audits of psychotropic medication.

I am satisfied the provider had systems and processes in place to manage chemical restraint and ensure psychotropic medication is used as a last resort. Whilst there were three consumers who, at the time of the assessment contact, were not correctly identified as subject to chemical restraint, the provider acted promptly to address this and put relevant documents in place. I have also placed weight on information that documentation for two of the consumers had previously been in place (but deleted in error) and the third consumer had not received the medication in the past four months.

*Environmental restraint*

The Assessment Contact Report identified that most consumers (excluding those who reside in the memory support unit), who were otherwise physically capable, were prevented from leaving the service independently. This had not been identified as a form of environmental restraint, and therefore not managed in line with legislative requirements for the use of restrictive practices.

In response to the Assessment Team’s feedback during the assessment contact, management proposed remedial actions, including unlocking the main perimeter gate, identifying and managing consumers environmentally restrained, and providing staff information about consumers who can leave the premises independently.

The approved provider’s response to the Assessment Contact Report included evidence of actions taken to facilitate easy exit/entry to the service via the main gate, manage environmental restraint and raise staff awareness. For example:

* The main gate now opens automatically and requires a code for exit that is clearly displayed on the keypad lock.
* All stakeholders (including consumers, their representatives and staff) have been notified about the new gate access protocols via a memorandum, email and messaging systems.
* Environmental practices and risk assessments for consumers have been reviewed and documentation updated to include care strategies and safety measures. Required documentation has been completed for those consumers subject to environmental restraint.
* Staff have been informed about consumers’ freedom to leave the service and those consumers that are subject to environmental restraint.

I note the provider has acted promptly to address deficiencies with environmental restraint and that actions have been completed. I am satisfied that processes are now in place to ensure environmental restraint is appropriately identified and managed, and that those consumers who are not subject to environmental restraint can freely and independently enter and exit the service as they wish.

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)