Performance

Report

**1800 951 822**

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| Name of service: | Forest Lodge Residential Aged Care |
| Service address: | 23 Forest Drive FRANKSTON NORTH VIC 3200 |
| Commission ID: | 3825 |
| Approved provider: | Great Oaks Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 October 2022 to 19 October 2022 |
| Performance report date: | 16 November 2022 |

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 Lodge Residential Aged Care (**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.

# 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)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |

Findings

The service was found non-compliant in Requirement 2(3)(c) at the last visit. The scope of the assessment contact was to assess the service’s progress in returning to full compliance for this requirement.

The service demonstrated ongoing partnership with consumers and their representatives in the assessment, planning, and review of consumer’s care and services. Staff and management demonstrated knowledge about how the consumers, representatives, and other health professionals collaborate to ensure the delivery of safe and individualised care. Care documentation reflected communication with representatives and input from other health professionals when changes in consumers’ care occur and when restrictive practices are considered.

All nine consumer files reviewed evidenced appropriate consultation with consumers’ nominated representatives and, where appropriate, included input from health practitioners. A representative interviewed confirmed the service communicates with them about the consumer they represent and that they are included in conversations about the consumer care with other health professionals.

The service demonstrated that actions undertaken to date have fully addressed the deficits previously identified. Interviews, observations, and review of care planning documentation demonstrated the service is meeting the requirement.

I find the service is Compliant with requirement 2(3)(c).

# 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

The service was found non-compliant in Requirement 3(3)(a) at the last visit. The assessment contact scope included assessment of the service’s progress in returning to full compliance for this requirement.

The service demonstrated improvement in the assessment, management, monitoring, and review of restrictive practices. Care documentation reviewed show informed consent is obtained and updated as required. Nine of the 9 consumers and representatives interviewed said they received communication from the geriatrician or the medical practitioner in relation to the use of psychotropic medications including its benefits, risks, side effects and alternative treatment.

The Assessment Team noted all care files reviewed reflected consultation between consumers/ representatives, allied health professionals and the treating clinical team. Three consumer files reviewed had evidence of de-prescribing psychotropic medications. Eight of 9 consumers reviewed had a completed behaviour support plan in place. Staff demonstrated knowledge of individual consumers’ current needs, the triggers for their behaviour, and the effective strategies put in place to manage consumers’ changed behaviour.

Regular multidisciplinary team meetings and consultations are held to discuss consumer’s care and consultation occurs with a multidisciplinary medication advisory committee to promote the quality use of medications. The medical practitioner advised they consult with the relevant specialist prior to prescribing psychotropic medications.

The Assessment Team observed consumers in the memory support unit. The consumers were alert and are engaging in activities. Staff were observed redirecting, reassuring, offering food, and engaging in one-on-one conversation with consumers.

The service has addressed the deficits previously identified. Interviews with staff and management, observations, and review of care planning documentation demonstrated improvement in the assessment, management, monitoring, and review of restrictive practices.

I find the service is Compliant with requirement 3(3)(a).

# 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 found non-compliant Requirements 8(3)(d) and 8(3)(e) at the previous assessment contact. The scope of the most recent assessment contact was to assess the service’s progress in returning to compliance for these requirements.

The service provided organisational documentation such as frameworks and policies and procedures to support the management of risk in response to incidents and demonstrated their implementation. Management and staff described high impact or high prevalence risks associated with the care of consumers risks, such as falls and how they are managed within the service.

This includes discussion with consumers and representatives and a suite of assessments completed for consumers on entry to the service and through ongoing observations, incident review, audits and feedback. A Resident Risk Management Policy and Procedure guides this process. Falls management has been improved after further education was provided to staff

Consumers are supported to take risks and live the best life they can, and any risks are managed. Activities provided are informed by feedback provided at meetings attended by the Chief Executive Officer and then actioned accordingly. A register is maintained for reporting incidents. The service has a Resident Reportable Incident Policy and Procedure. It guides requirements relating to reportable and non-reportable events. Staff have received education in relation to the Serious Incident Response Scheme (SIRS) and the incident management system and are knowledgeable about their reporting responsibilities based on their position.

The service has demonstrated it has effective risk management systems and practices in place, informed by policies and procedures, implemented by staff and management. Staff are informed about their roles and responsibilities in managing and reporting risk. Risk registers are maintained, and incidents are recorded and reported.

The service had a documented clinical governance framework and policies on antimicrobial stewardship, minimising the use of restrictive practices and open disclosure which inform staff practice. Staff demonstrated an understanding of the framework and policies. Staff have been educated in promoting appropriate use of antibiotics, understanding antibiotic guidelines, prescribing antibiotics for the right reasons and practicing hand hygiene. Staff follow the organisation’s restrictive practice policy and seek consent from the consumer/representatives prior to restrictive practices being applied. Open disclosure is understood by staff and implemented when things go wrong along with apologies to those involved. Antimicrobial stewardship is understood by staff who identify infections, undertake pathology testing and use of alternative strategies to minimise the use of antimicrobials. Staff provided examples of using open disclosure and antimicrobial stewardship.

I find the service is Compliant with requirements 8(3)(d) and 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)