Performance

Report

**1800 951 822**

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| Name of service: | Hocart Lodge |
| Service address: | 3 Knowles Street HARVEY WA 6220 |
| Commission ID: | 7051 |
| Approved provider: | Great Southern Care Company Aged Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 October 2022 |
| Performance report date: | 8 December 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 Hocart 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 - 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 28 November 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **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

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Standard 3 Requirement 3(3)(b) – ensure where restrictive practice is used that it is reviewed and monitored for effectiveness and used for a as sorter time as possible. This includes gaining informed consent and having an effective behaviour management plan that assists to minimise the use of restrictive practice.

# 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. | Non-compliant |

Findings

The Assessment Team recommended Requirement 3(3)(a) as Compliant and Requirement 3(3)(b) as Non-compliant as the service could not demonstrate the use restrictive practice is as a last resort or for as short a time as possible and five consumers have not had a restrictive practice assessment.

Consumer A’s behaviour support plan does not include any information in relation to chemical restraint and staff could not demonstrate that alternative strategies or interventions were trialled prior to the administration of psychotropic medication. Consumer A was observed sitting in a chair at 9.30am, asleep.

Consumer B has been on long term psychotropic medication, again where the service was not able to demonstrate alternative strategies or interventions were trialled prior to the administration of the psychotropic medication. Consumer B does not have a behaviour support plan to guide staff in managing psychotropic medications.

Both Consumers A and B were raised with management who stated the clinical nurse manager was working on restrictive practices and the general practitioner could look at reducing Consumer B’s medication. Management also acknowledged they have not completed restrictive practice assessments for 12 of 17 consumers using a chemical restrictive practice.

The provider responded to the Assessment Team’s report on 22 November 2022 stating that both consumers had had their psychotropic medications either ceased, changed or reduced.

One of Consumer A’s psychotropic medications was ceased on 31 March 2022 and the observation of the consumer appearing to be sleep at 9.30am was congruent with their current condition of degeneration since recovering from COVID. Consumer B has had several changes in medication listed along with the assertion that the effects of the psychotropic medication were being closely monitored by the service.

They said in their response the management team are cognisant of all legislative requirements and are working toward full integration of systems to maintain compliance as the provider only took over the service on 01 December 2021. They also provided a comprehensive continuous improvement plan which shows they are continuing to address any deficits with restrictive practices.

I have reviewed both the Assessment Team’s report and the provider’s response carefully and found it difficult to determine whether the service is compliant with the requirements of minimisation of restraint legislation therefore managing the high prevalence high risk practice of restrictive practice. Whilst the provider did state the medications have been either ceased, changed or reduced, the response did not make mention of either consumers’ behaviour support plans or what occurs prior to the administration of as required psychotropic medications or whether assessments have now been completed for all consumers on restrictive practices.

In making my decision I have relied on the information from management which was taken during the Assessment Contact visit which shows that five consumers did not have restrictive practice assessments, the clinical nurse was working on restrictive practice, and Consumer B could be considered for a reduction in medication.

These statements to me, do not show that at the time of the Assessment Contact that the high prevalence high risks associated with restrictive practices for some consumers were being managed in line with legislated requirements. Accordingly, I find Requirement 3(3)(b), Effective management of high impact or high prevalence risks associated with the care of each consumer, Non-compliant.

In relation to Requirement 3(3)(a), consumers confirmed they receive personal and clinical care that is safe and right for them. Staff could describe the care they provide to consumers that is tailored to the individual needs and is safe and effective. Care files reviewed showed that overall the service is providing clinical care that is best practice.

Accordingly, I find 3(3)(a), Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; is tailored to their needs; and optimises their health and well-being, Compliant.

However, as one Requirement is Non-compliant I find the overall rating for Standard 3 Personal care and clinical care Non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

The service was previously found Non-compliant at an Assessment Contact visit conducted on 20 August 2021. The service did not have effective systems to ensure there are enough staff with different levels of skills and abilities to meet consumer needs. The service undertook a recruitment drive to ensure they had the appropriate amount of suitably skilled staff for all positions and changed the registered nursing shifts to 12 hours each to ensure they could maintain 24 hour coverage of nursing. The Assessment Team has now recommended this requirement is Compliant.

Consumers and representatives confirmed they are satisfied with staffing levels at the service. Staff stated they have enough time to complete their tasks and vacant shifts are filled on most occasions. Documentation confirmed that most shifts are filled by either ongoing or agency staff.

The provider did not add any additional information in relation to staffing in its response.

I have considered the information presented in the Assessment Team’s report and I agree with both consumers and staff being satisfied with staffing numbers the service has made adequate changes to address the staffing issues.

Accordingly, I find Requirement 7(3)(a), The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services, Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |

Findings

The previous provider was found Non-compliant in an Assessment Contact conducted on 20 August 2021, as they did not demonstrate effect governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The persons who were responsible to conduct these functions left the service with no notice and there were no others to take their place. The service has since been managed by a new provider and it has people to fulfil these functions.

The current provider has undertaken other activities for improvement including clinical education for all appropriate staff on an electronic care platform, review of staff files for qualifications and experience to ensure workforce needs can be met. The complaints system has undergone improvement including identification of opportunities for improvement through analysis of feedback, incidents, staff performance and internal audit mechanism and an open door policy implementation and feedback boxes distributed throughout the service.

The Assessment Team recommends this requirement is Compliant as they found the provider does have effective governance systems. Staff confirmed they have access to the information they require about consumers, and policies and procedures are available and accessible to them. Continuous improvement was effective with a log to list items and monitor the progress towards the listed goals. Management is supplied with a yearly budget which is broken down into different departments and the finance team is involved in monthly management meetings. There is now a central human resource team who assists to ensure that workforce governance requirements are met. The organisation has responsibility to ensure the provider is aware of regulatory compliance obligations along with a corporate responsibility to ensure they comply with these requirements. The feedback and complaints system has been overhauled to ensure it is effective.

The provider did not add any additional information in relation to governance in its response.

I have considered the information presented in the Assessment Team’s report and I agree that the provider does have effective governance systems as listed in this Requirement.

Accordingly, I find Requirement 8(3)(c), Effective organisation wide governance systems relating to the following: information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints, 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)