Performance

Report

**1800 951 822**

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| Name of service: | Kellock Lodge |
| Service address: | 15 Bon Street ALEXANDRA VIC 3714 |
| Commission ID: | 3311 |
| Approved provider: | Kellock Lodge Alexandra Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 May 2023 |
| Performance report date: | 19 June 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 Kellock Lodge (**the service**) has been prepared by D.Fekonja, 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 13 June 2023.

# Assessment summary

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| 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 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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)(b) and 2(3)(e) following a Site Audit from 17 May 2022 to 20 May 2022. The service did not demonstrate that assessment and planning adequately address risks to consumer health and well-being. In addition, the service did not demonstrate that changes to consumer needs are effectively documented and reviewed to ensure current strategies meet consumer needs. Consumer assessment and care planning information was recorded across two different systems which created the potential for risk to the continuity and the delivery of safe and effective care.

The service’s plan of continuous improvement dated 30 December 2022 included actions to address the issues identified. The service now has all consumer assessment and care planning information contained in one electronic care planning system.

Consumers and representatives expressed confidence the service’s care planning process informed safe, person-centred care. Care planning documents reflect the outcomes of a range of risk assessments including in relation to falls, nutrition, skin integrity, responsive behaviours and specialised care needs for each consumer including those receiving respite care. Staff were able to explain the process of assessment and planning for consumers admitted to the service for both permanent and respite care.

A senior clinical staff member has oversight of the care planning process and guides staff in its implementation. Staff use the electronic care planning system and handover documents to find out about a consumer’s care needs and preferences. Training and one on one feedback has also been provided to staff on care documentation requirements.

Most consumer files had been reviewed within the last six months. There was, however, some inconsistency in the review of care and services following a change a in consumer’s health condition form on return from hospital. There was no negative impact to consumers’ care in this case.

The approved provider in their response has outlined further improvements to their processes, such as ensuring all forms on a consumer’s return from hospital are overseen and signed off by the Director of Nursing.

The Assessment Team found Requirements 2(3)(a), 2(3)(b) and 2(3)(e) were met. Based on the evidence presented during the Assessment Contact and the further information submitted by the approved provider I find the service compliant with these Requirements.

# 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. | Compliant |

Findings

The service was found non-compliant in Requirements 3(3)(a) and 3(3)(b) following a Site Audit from 17 May 2022 to 20 May 2022. The service did not demonstrate that it provided best practice care specifically in relation to the management of wounds, pain and behaviour support planning for consumers subject to restrictive practices. The service also did not effectively monitor consumers following a fall. Clinical monitoring after an incident was not consistently completed and existing prevention strategies were not formally reviewed for effectiveness.

The service has implemented several actions in response to the non-compliance identified at the Site Audit from 17 May to 20 May 2022 which are contributing to improvement. This includes the following:

* The introduction of an electronic care planning system which alerts staff to wound care and helps clinical staff track management of documentation;
* The provision of online training in wound education to 6 nurses and a wound consultant was engaged initially to upskill staff;
* A senior clinical staff member has been given oversight of the care planning process including monitoring of wound care practices;
* Post fall processes were revised and education provided to ensure falls were documented, assessments conducted and there was effective post fall monitoring;
* Behaviour case conferences have been initiated to develop greater understanding of the causes of responsive behaviours including unresolved pain and communication issues.

During the Assessment Contact conducted on 17 May 2023 the Assessment Team found wound care practice and behaviour support planning for consumers were generally in line with best practice. Staff identify and respond to consumers who experience pain and generally evaluate effectiveness of the response. However, systematic monitoring of pain through charting and review of pain assessments does not occur in line with the service’s pain management policy.

One consumer who suffers pain due to their medical condition did not have pain charting or the reason for the pain added to their pain assessment. The service’s pain policy states 3-day pain charting should be commenced when pain is identified or indicated, however, the Assessment Team found very few examples of pain charting for any of the consumers they reviewed. There were discrepancies with staff understanding of the policy.

The service’s psychotropic register did not contain the details of one consumer’s psychotropic medications or another’s sleep medication. The register listed 35 residents receiving psychotropic medications with evidence of just 2 medication reviews last conducted in June 2022. This was said to be updated immediately during the Assessment Contact.

There was also no evidence that wounds were being consistently measured or that repositioning to prevent and assist with pressure injuries was being consistently performed.

Consumers and representatives were satisfied staff worked hard to reduce the risk of falls occurring and safely managed falls incidents. However, the Assessment Team found while consumers received safe immediate post fall care, neurological observations were not consistently performed as per the service’s policy. For one consumer there was an inconsistency between documented falls prevention strategies and the application of these strategies.

The approved provider has responded to the deficits identified by the Assessment Team and have implemented reviews of clinical care policies and processes. They have conducted consumer reviews and updated pain assessments and pain charting. This is to be reviewed monthly at first to ensure it is embedded in practice. Alerts have been added to the electronic system to ensure repositioning occurs and wounds are to be measured when photos are taken.

The psychotropic register has been updated and is to be reviewed bi-monthly by the nursing staff and there will a monthly review of consumers who are prescribed psychotropic medications for behaviour support.

The Assessment team found Requirements 3(3)(a) and 3(3)(b) not met at the time of the Assessment Contact. I have come to a different view based on the updated information on the improvements submitted by the approved provider and their commitment to ensuring the improvements are embedded in practice.

I find the service compliant with Requirements 3(3)(a) and 3(3)(b).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was found non-compliant in Requirements 7(3)(d) and 7(3)(e) following a Site Audit from 17 May 2022 to 20 May 2022. The service did not demonstrate that mandatory training was completed, or that staff were supported during a transition to a new electronic care file system. Furthermore the service did not demonstrate they had procedures in place to monitor and review staff performance. The service’s plan of continuous improvement dated 30 December 2022 included actions to address staff training and the performance appraisal process.

The service has implemented actions to address these deficits which have been effective. For example:

* Face–to–face education is offered at each staff meeting;
* Mandatory education is offered via online modules, including Serious Incident Response Scheme (SIRS);
* Overdue training reminders are sent weekly to staff;
* A 2023 education calendar is provided in the staff room and also emailed to the staff;
* The delivery of further support and training on the services electronic care planning system;
* Implement a systematic appraisal process;
* Invite staff to participate and create an appraisal schedule;
* Send reminders for staff overdue in the appraisal schedule.

During the Assessment Contact conducted on 17 May 2023, documentation viewed and interviews conducted by the Assessment Team, demonstrated the service has provided a range of education sessions to staff at orientation and for regular and agency staff. The start time of the afternoon shift has been brought forward half an hour to ensure staff are on-site to receive training for half an hour prior to their shift.

Staff confirmed they participate in annual appraisals and described and use this to identify training needs or professional development. The Director of Care allocates one morning a week to conduct staff appraisals. Staff are also provided with tools and training to ensure their development goals are being met.

Representatives interviewed were satisfied that staff were well trained and knew what they were doing.

The Assessment Team found Requirements 7(3)(d) and 7(3)(e) were met. Based on the evidence I find the service has made the necessary improvements to rectify the deficits identified at Site Audit from 17 May 2022 to 20 May 2022 and is compliant with Requirements 7(3)(d) and 7(3)(e).

# 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 service was found non-compliant in Requirement 8(3)(c) following a Site Audit from 17 May 2022 to 20 May 2022. The service did not demonstrate that deficits in relation to information management and continuous improvement governance were addressed. Deficits were captured in policies that didn’t reflect current legislative requirements, continuous improvement was not captured or evidenced, and the transfer of information from information systems was not effective. The service has implemented actions from the plan for continuous improvement dated 30 December 2022 to address these deficits which have been mostly effective. For example:

* The service has purchased a suite of policies and procedures and is in the process of reviewing the policies to integrate specifically into local procedures.
* The quality improvement register has been separated from the complaints register.

During this Assessment Contact conducted on 17 May 2023, the Assessment Team found the service demonstrated effective governance systems in relation to information management. However, the service did not demonstrate effective systems or processes in place related to regulatory compliance, specifically the lack of identification of incidents that required reporting under the requirements for the Serious Incident Response Scheme (SIRS).

Numerous incidents that required reporting to the Commission under SIRS reporting guidelines, including neglect, and unreasonable use of force were not reported.

The approved provider submitted information in relation to the improvements they have made to ensure the service meets its legislated requirements in relation to SIRS. This includes increasing the number of staff that can report SIRS to the Commission, adding SIRS reporting to the Quality Committee agenda and being aware of and using Commission resources in relation to investigating and managing incidents.

The Assessment Team found this Requirement not met but I have come to a different decision. I am satisfied that the approved provider now understands their reporting requirements in relation to SIRS and have seen evidence that they have submitted SIRS reports to the Commission in relation to incidents that have occurred in the service since the Assessment Contact, including those previously identified as not being reported correctly.

Based on this evidence I find the service is compliant with Requirement 8(3)(c).

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)