Performance

Report

**1800 951 822**

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| Name of service: | Lake Haven Court Aged Care Facility |
| Service address: | 5 Stratford Avenue CHARMHAVEN NSW 2263 |
| Commission ID: | 0707 |
| Approved provider: | Alino Living |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 11 August 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 Lake Haven Court Aged Care Facility (**the service**) has been prepared by J Earnshaw 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 Site Audit; the Site Audit 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 3 August 2023
* other information and intelligence held by the Commission in relation to the service

# Assessment summary

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| Standard 3 Personal care and clinical care | 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 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 |
| 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

The service was found non-compliant under requirements 3(3)(e) following a Site Audit conducted 1 February 2022 to 3 February 2022. Deficiencies related to the service being unable to demonstrate adequate documented information regarding consumers’ conditions, needs and preferences or that behaviour support plans were in place to meet restrictive practice regulatory compliance regarding consumers subjected to environmental restraint.

The assessment contact conducted 11 July to 12 July 2023 also assessed requirements 3(3)(a) and 3(3)(b). The assessment team report recommended these requirements as non-compliant and recommended ongoing non-compliance in requirement 3(3)(e). The assessment team report advised the service was unable to demonstrate effective processes to ensure timely referrals to allied health professionals, or that care planning documentation is shared or provides complete and accurate information to guide staff, and others in the provision of safe and effective care and services.

The assessment team report also described actions taken by management at the time of the assessment contact, including in regard to environmentally restrictive practices by ensuring consumers had access to keypad codes as appropriate and outlined measures committed to by management on the deficiencies raised by the assessment team.

I acknowledge the multiple areas of improvement demonstrated by the Approved Provider, in their response, including-

* Reviewed policies and assessments as relevant to these requirements
* Reviewed consumers care needs, including diabetic management, falls, smoking, and restrictive practice
* Revised handover processes and implemented an electronic handover tool
* Automatic clinical alerts added to the electronic care system
* Education provided to staff including on diabetes management, dementia, mental health referral pathways, restrictive practices and revised policies
* Monthly clinical auditing and review of the audit system for quality assurance
* Additional allied health hours utilised to assess consumer mobility and falls risks
* The service completed a review of all consumers with behaviour support plans and completed a care needs review of named consumers to ensure current needs and preferences are documented and available to staff
* Smoking assessments have been conducted for consumers who choose to smoke, and education provided to consumers and staff on the requirement to use the new designated smoking area fitted with fire fighting equipment
* Clinical meetings held to discuss matters identified by the assessment team and the measures implemented at the service, in response to these matters

Consumers/representatives said consumers are receiving safe and effective clinical and personal care. Consumers/representatives said they feel staff know consumers’ needs and preferences and information is shared appropriately with representatives and others.

Staff were able to describe how consumer information and changes to condition are documented, discussed at handover and accessible within the electronic care management system.

In response to the previous non-compliance, the assessment team report advised of the following actions taken by the service:

* The service engaged a nurse practitioner wound specialist to provide wound management recommendations and support within the service.
* purchase of recommended pressure injury prevention equipment
* The service implemented education sessions for all care staff regarding pressure injury care.
* monthly auditing to monitor diabetic management and education provided to staff regarding the diabetic management policy
* Consumer dietary requirements and dietitian recommendations are recorded in the electronic care management system and updated consumer needs are provided to food service staff to guide food service practices

In coming to my decision for these requirements, I have considered the information included in the assessment team report alongside the approved provider’s detailed response and their commitment to continuous improvement evidenced by the implementation of the described actions.

I am persuaded by positive consumer feedback and the Approved Provider’s response, that the service has addressed the deficiencies identified under these requirements. Therefore, I find these Requirements 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 service was found non-compliant under this requirement following a Site Audit conducted 1 February 2022 to 3 February 2022. Deficiencies related to the service being unable to demonstrate adequate assessment and record management of behaviour support plans for environmental restrictive practice.

The assessment team report recommends ongoing non-compliance in this requirement as the service was unable to demonstrate effective governance systems in place relating to information management and regulatory compliance. Specifically in relation to handover documentation, environmental restrictive practices, and effective reporting of reportable incidents. However, the assessment team report also outlines immediate actions committed to by management at the time of the assessment contact.

The service demonstrated effective governance systems relating to continuous improvement, financial governance, workforce governance and feedback and complaints.

The Approved Provider submitted an extensive response, plan of continuous improvement and supplementary evidence demonstrating the implementation of actions to remedy the previously identified non-compliance as well as the deficiencies identified at this assessment contact.

I have considered this detailed response which demonstrates consideration of, and actions taken in response to the deficits raised in the assessment team report, as considered under other requirements.

I acknowledge the areas of improvement described by the Approved Provider, and that although they have a different opinion to the assessment team in relation to the reportable incident described in the assessment team report, the response provides further information on how incident reporting occurs, is monitored and escalated and reporting of all priority 1 incidents to the Care Governance Committee through the Quality Care Advisory Report.

I am satisfied that adequate measures have been implemented at the service to ensure effective information management and regulatory compliance.

In coming to my decision of compliance with this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s response and the demonstrated continuous improvement evidenced by the implementation of activities of improvement.

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)