Performance

Report

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| Name: | Lilliane Brady Village Nursing Home |
| Commission ID: | 2699 |
| Address: | 2 Nullamutt Street, COBAR, New South Wales, 2835 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 21 May 2024 to 22 May 2024 |
| Performance report date: | 25 June 2024 |
| Service included in this assessment: | Provider: 1247 Cobar Shire Council  Service: 1056 Lilliane Brady Village Nursing Home |

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 Lilliane Brady Village Nursing Home (**the service**) has been prepared by D Utting, 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.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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 2

* Requirement 2(3)(a) – the approved provider ensures assessment and planning is completed comprehensively and accurately and considers risks to the consumer’s health and well-being.

Standard 3

* Requirement 3(3)(a) – the approved provider ensures each consumer receives safe and effective personal and clinical care including pain management.

Standard 7

* Requirement 7(3)(d) – the approved provider ensures the workforce is trained and supported to deliver safe and quality care.

Standard 8

* Requirement 8(3)(c) ensures effective information management, identification of risk, monitoring of the performance of the workforce governance and using incidents to improve care and services.
* Requirement 8(3)(e) implement and sustain an effective clinical governance framework with supporting policies and processes.

# 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. | Not Compliant |

Findings

The service was found non-compliant in Requirement 2(3)(a) following a site audit conducted 20 June 2023 to 22 June 2023. At the time, the service was unable to demonstrate that consumers subject to environmental restrictive practices had appropriate care planning documentation in place to guide staff practice.

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service did not demonstrate assessment and planning considered risks or the potential impact of these risks to inform the delivery of care. The use of validated assessment tools to identify pressure injury risks were not consistently used. Consumers with pressure injuries did not have wound assessment and treatment plans in place to guide staff. Consumers subject to the use of mechanical restrictive practices did not have documented risk assessments. Staff could not explain how they consider risk or use of incident reports as part of assessment processes and or the completion of behaviour support plans (BSP’s).

During the Assessment Contact management acknowledged they would address the identified deficits in risk assessment and BSP’s and were in the process of employing a wound care specialist to complete weekly reviews of consumers. The service did not provide any further information in response to the Assessment Team’s report. I am satisfied with the evidence presented in the Assessment Team report that the service is not effectively assessing and planning consumer care, including consideration of risk. I find the service non-compliant with this Requirement.

# 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. | Not Compliant |

Findings

The service was found non-compliant in Requirement 3(3)(a) following a site audit conducted 20 June 2023 to 22 June 2023. At the time the service did not demonstrate the identification and monitoring of consumers subject to environmental restrictive practices.

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service did not demonstrate there were processes to ensure there is effective and safe management of each consumer’s clinical care, particularly in relation to behaviour management, psychotropic medication administration and wounds. Staff did not demonstrate an understanding of the use of chemical restraint, management of triggers for consumers changed behaviours, pain management and individualised wound care. Care planning documentation did not evidence the use of non-pharmacological interventions prior to the administration of as needed psychotropic medication. Pain was not considered a trigger for changed behaviour. There was no process in place to prompt staff to evaluate the effectiveness following the use of as required pain or psychotropic medication. Wound care was not tailored to the consumer’s assessed needs, resulting in consumers pressure injuries deteriorating.

The service did not provide a response to the Assessment Team’s report. While the service demonstrated they were managing some aspects of clinical care effectively and safely, such as diabetes, weight loss and catheters, they did not demonstrate effective management of chemical restrictive practices, psychotropic medication and wounds. I am satisfied with the evidence presented in the Assessment Team report and find the service non-compliant with this Requirement.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-compliant in Requirement 6(3)(d) following a site audit conducted 20 June 2023 to 22 June 2023. At the time, the service did not demonstrate feedback and complaints were analysed and used to inform continuous improvement.

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service demonstrated the actions taken in response to the non-compliance have been effective. These improvements included the implementation of a feedback and complaints handling program and reporting to the organisation’s governance area on complaints trends and outcomes. The service demonstrated feedback and complaints are reviewed and used to improve the quality of consumer care and services. Management explained how they use the feedback and complaints to identify improvements. Consumers have a variety of ways to submit feedback and complaints. The feedback register evidenced improvements to care and services as a result of consumer feedback.

I am satisfied with the evidence presented in the Assessment Team report and find service compliant with this Requirement.

# 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. | Not 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 conducted 20 June 2023 to 22 June 2023. At the time the service did not demonstrate there was an effective system to monitor the staff completion of mandatory training, resulting in low compliance levels. There were deficiencies in staff knowledge of restrictive practices and the Serious Incident Response Scheme (SIRS). The service was not regularly monitoring staff performance.

In relation to Requirement 7(3)(d)

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service did not demonstrate the improvement actions have been effective to address the non-compliance with this Requirement. Staff mandatory training records evidence low completion rates. Management could not explain the system for follow up of staff who do not complete mandatory training modules. Staff demonstrated a lack of knowledge in relation to restrictive practices, wound management, incident identification and reporting. Training modules in relation to these topics had low staff attendance rates. The service did not demonstrate that they use incident data to identify staff training needs.

The service did not provide a response to the Assessment Team’s report. While management acknowledged awareness of the low compliance with mandatory training, no further information detailing how the service will ensure the staff are trained and supported to deliver safe and quality care and services has been provided. I am satisfied with the evidence presented in the Assessment Team report and find the service non-compliant with this Requirement.

In relation to Requirement 7(3)(e)

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service demonstrated the actions taken in response to the non-compliance have been partially effective. The service has implemented a performance assessment policy and a system of staff self-appraisals for full time staff. The service has no policy and procedure in place for the formal monitoring of casual and part-time staff employed at the service.

Staff explained how they complete the self-appraisal and meet with the facility manager to review performance. Staff also described how they meet with the clinical care coordinator for informal performance development discussions.

The service did not provide a response to the Assessment Team’s report. I acknowledge the service has addressed some elements of the non-compliance and I am satisfied the improvement actions have been effective to ensure there is a system in place to ensure the formal performance monitoring of full time staff. Given a high percentage of the workforce is part-time or causal I encourage the service to consider how they ensure they are formally monitoring the performance of this workforce. I find the service compliant with this Requirement.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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. | Not Compliant |
| 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. | Not Compliant |

Findings

The service was found non-compliant in Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit conducted 20 June 2023 to 22 June 2023. At the time the service did not demonstrate;

* there were a range of opportunities for consumers to engage in the development, delivery and evaluation of care and services.
* the governing body promoted a culture of safe, inclusive, and quality care and services and was accountable for the delivery.
* effective organisation wide governance system were in place, such as reporting risk and continuous improvement opportunities to the governing body, monitoring staff training and performance and using complaints and feedback to improve service delivery.
* effective incident management systems and escalation processes to the governing body.
* Effective clinical governance.

In relation to Requirement 8(3)(c)

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service did not demonstrate there are effective governance systems in place relating to information management, workforce governance, continuous improvement, and regulatory compliance.

Review of the Electronic Care Management System (ECMS) evidenced inaccurate documenting of consumers clinical care needs. Staff explained how they were not able to use the ECMS effectively to ensure information recorded reflects the consumers’ current care needs and preferences. Staff do not have access to policies that are current or tailored to the service. Management did not provide a timeframe for when staff would have access to policies and procedures and be trained.

While the service was demonstrating effective use of feedback and complaints to improve services, the collection of data to inform clinical indicators and incident reporting are not effective. The service is not currently completing internal auditing and this had not been reported to the governing body. The service did not demonstrate that staff were trained and skilled, in the use of the ECMS and behaviour management/restrictive practices which form part of workforce mandatory training. There was not an effective system in place to monitor the completion of mandatory training and identified training has either not occurred or has minimal staff attendance. Management could not describe how the performance of part-time/casual staff is formally monitored.

The service did not provide a response to the Assessment Team’s report. I am satisfied with the evidence presented in the Assessment Team report in relation to the service not having organisation wide governance systems in place to ensure effective oversight of information management, continuous improvement and workforce training and performance. I find the service non-compliant with this Requirement.

In relation to Requirement 8(3)(e)

At the Assessment Contact conducted 21 May 2024 to 22 May 2024, the service did not demonstrate an effective clinical governance framework to ensure the quality and safety of clinical care, including minimising the use of restraint. The service’s clinical governance documentation reviewed by the Assessment Team did not evidence alignment of current clinical policies with best practice, for example reflecting current restrictive practices legislation. Management explained there was no process for antimicrobial stewardship, with medical officers following their own processes. Clinical auditing is not occurring. Incidents, such a pressure injuries and medication errors were not consistently reviewed and analysed to ensure care strategies are tailored to consumer needs. Staff responsible for clinical governance did not understand environmental restrictive practices or how to use incident data analysis to improve service delivery.

The service did not provide a response to the Assessment Team’s report. While I acknowledge the service’s completed actions, there continues to be concerns with the service’s capacity to support effective clinical oversight. As a result, and with consideration to the available information I find this Requirement not compliant.

Compliance with the remaining Standards

Consumers and representatives were satisfied with how the service engages with them in the development and delivery of care and services. Management explained the different ways they engage with consumers and representatives, such as the introduction of a reference committee which includes consumer representatives. The committee can influence council decisions into the aged care services. The Assessment Team review of documentation demonstrated the service is using feedback from consumers and representatives to make improvements.

Consumers, representatives, and staff are satisfied the council/service provides culturally safe and inclusive care. Documentation review evidenced reporting of national quality indicator data and risks to the governing body. Cultural and diversity training has been provided to staff and the council strategic plans include the ‘Lillian Brady” service.

The service demonstrated there are processes in place for managing risk, which includes a risk matrix, risk analysis and a risk register. Management interviewed could explain high impact, high prevalence risks for the organisation and their responsibilities to report abuse or neglect. The service did not demonstrate that clinical risks to consumers are consistently identified, assessed and mitigation strategies documented. Incidents are not consistently analysed to understand the opportunities to mitigate future risk and improve care and services for individual consumers. Internal auditing is not currently being completed. I am satisfied that the improvement actions have been effective to ensure there is a risk management system in place. I encourage the service to investigate improvements to the systems and processes to ensure staff are able to consistently identify risks for consumers, completing assessment and planning for these risks and using incident reporting data to minimise risk.

I am satisfied with the evidence presented in the Assessment Team report and find service compliant with Requirements 8(3)(a), 8(3)(b) and 8(3)(d).

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)