Lions Haven For The Aged

Performance Report

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**Commission ID:** 5188

**Provider name:** Lions Haven for the Aged Limited

**Assessment Contact - Site date:** 18 May 2022

**Date of Performance Report:** 13 June 2022

# Performance report prepared by

Susan Turner, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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 Infection Control Monitoring Checklist completed 18 May 2022
* the provider’s response to the Assessment Contact - Site report received 8 June 2022

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The service has processes in place to support the effective management of high impact and high prevalence risks associated with the care of consumers.

Consumers expressed satisfaction with the care they received and said that staff explained the care they provide and managed risks associated with their care. Consumers felt this optimised their sense of well-being.

The Assessment Team reviewed care related documentation for consumers with a range of conditions including those with chronic pain and those who present with complex behaviours. For consumers with pain, assessments had been completed, pain levels were charted, and pharmacological and non-pharmacological pain management strategies were utilised and evaluated for effectiveness. The medical officer was involved when pain management strategies were found to be ineffective.

For consumers who present with complex behaviours, the Assessment Team found that assessments and behaviour support plans were completed. Behaviour support plans included behavioural triggers and strategies to support consumers and minimise behaviours. For consumers with recurring behaviours, allied health specialists including a dementia advisory service have been contacted and have contributed to the care of the consumer.

Staff were aware of consumers’ needs and provided examples of the strategies they use to manage consumers’ pain and to minimise complex behaviours where the consumer may pose a risk to themselves and/or others. Staff explained how they monitor consumers who have experienced an incident or who have had a change in their care; for example, a change in their pain medication.

Staff said that they access specialist services for those consumers who have complex needs including consumers who are at end of life. Staff advised a specialist palliative care team visits the service monthly to review consumers who have been referred to them. For consumers with chronic or acute pain that is difficult to manage, a referral is made to the local hospital for consultation with a specialist team that includes a medical officer and geriatrician if required.

Staff said they are supported by policies, procedures and care pathways. Care staff said they have access to registered nurses if they have any concerns about the consumers’ care needs including an adverse incident, pain, change in skin integrity or a fall.

Care delivery is monitored through various forums/mechanisms including the analysis of clinical indicator data, clinical care meetings (that are used to discuss psychotropic medications, falls, restrictive practices, pain, nutrition and behaviours), a psychotropic medication register and a medication advisory committee.

For the reasons detailed above this requirement is compliant.

### Requirement 3(3)(g) Compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The service demonstrated it has effective systems and processes to prevent and control infections and to reduce the risk of increasing resistance to antibiotics.

The service has taken action to address deficiencies that were previously identified under this requirement and the Assessment Team found the infection control program included contemporary practice in infection screening processes and the outbreak management plan included detailed information to guide staff in the event of an infectious outbreak. Management staff reported that improvements to the infection control program included:

* the engagement of an infection control consultant,
* a revision of the outbreak management plan,
* reduced entry points and improved screening processes,
* improved signage,
* regular rapid antigen testing of staff and visitors with registered nurses provided with training in completing rapid antigen testing,
* staff education and training,
* consumer and representative education and training,
* the revision/development of cleaning schedules,
* the appointment of a cleaning supervisor role, and
* completion of audits relating to infection control.

Consumers said they were satisfied with the information they received from the service in relation to COVID-19. They said they observed staff washing their hands regularly including prior to assisting them with cares and meals and that staff provided consumers with guidance about how to wash their hands.

Registered staff were aware of their responsibilities with respect to antimicrobial stewardship and were aware of the impact that hydration and hygiene had in relation to infection minimisation. Antimicrobial stewardship is included for discussion at the medication management advisory committee meetings.

Management staff advised the service has experienced COVID-19 outbreaks and the Assessment Team reviewed documentation relating to these incidents. The Assessment Team found the service worked with the Public Health Unit and the Department of Health and that instructions and guidelines were followed. Cohorting of staff and consumers occurred, staff shifts were extended and sufficient supplies of personal protective equipment were available. Staff and consumer vaccination status is monitored.

The organisation has written policies and procedures relating to infection control and anti-microbial stewardship.

The Assessment Team observed pre-entry screening occurring, infection control posters displayed in English and other languages, personal protective equipment and other infection control resources were available including hand sanitisers.

For the reasons detailed above this requirement is compliant.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

Consumers and representatives said they are encouraged and supported to provide feedback and make complaints. Consumers and representatives were aware of how to make a complaint and the majority said they felt comfortable raising concerns at meetings or speaking directly with staff or with the executive management team.

Consumers and representatives provided examples of how they use existing complaints and feedback avenues and said that management were responsive and addressed concerns that were raised.

Management staff said the organisation welcomes feedback and staff described the ways they support consumers by providing feedback forms, assisting them in completing the forms or by speaking to management on behalf of the consumer. Staff said they are in contact with consumers on a daily basis and are able to address issues and concerns promptly. Staff said they communicate consumer feedback to management staff by sending them an email, making a progress note entry, raising issues at staff meetings and completing feedback forms.

Consumers are provided with information about complaints in the agreement they are provided on entry to the service and complaints information is also displayed throughout the service.

Management reported the following actions have been taken in response to the deficiencies previously identified under this requirement:

* Feedback/suggestion boxes have been placed in various areas within the service increasing consumer access.
* Education and training relating to complaints handling has been provided to staff.
* A QR code has been provided which supports consumers and representatives to access the service’s internet site where they can provide feedback.
* The service has increased its monitoring of complaints and feedback mechanisms.

For the reasons detailed above this requirement is compliant.

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team found that appropriate action is taken by management in response to complaints and that an open disclosure process is applied.

Consumers and representatives were satisfied with management’s response and the information provided to them when they made a complaint. Consumers and representatives provided examples of the types of complaints they had made including in relation to food, care related concerns and requests relating to specific staff members. Consumers and representatives said their concerns were addressed and their requests were accommodated.

Management said feedback and complaints are recorded in the organisation’s database and that the complaints are acknowledged and investigated. Outcomes of the investigation including agreed actions are recorded on the service’s electronic care management system. An open disclosure policy is applied that includes providing clear information, a full explanation, emotional support and providing an apology. Complaints are reviewed by members of the executive management team to ensure they are handled in accordance with the organisation’s expectations in relation to appropriate action and open disclosure.

Management reported the following actions have been taken in response to the deficiencies previously identified under this requirement:

* The service has provided education and training relating to complaints handling.
* Feedback and complaints are discussed at meetings.
* The complaints policies and procedures have been reviewed and staff were familiar with these processes including in relation to:
  + complaints handling responsibilities
  + how to encourage feedback and provide confidentiality, and
  + open disclosure obligations.

The Assessment Team found that complaints are recorded on the complaints register. Feedback with outcomes achieved are discussed at staff meetings and Board meetings. Complaints records demonstrated that complaints have been managed in accordance with organisational requirements.

For the reasons detailed above, I find this requirement is compliant.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

Consumers said that when there was an issue that management responded promptly to address the situation and improve consumer outcomes. Consumers interviewed by the Assessment Team were satisfied with the care and services they received.

Consumers provided examples of the complaints they had made and how these were addressed by the service.

Staff said complaints previously made by consumers included delays in call bell response times. Staff said that in response, the executive management team advised consumers of how call bell response times were being monitored to ensure staffing levels were appropriate and explained that a recruitment process was underway to employ new staff. Staff said complaints had been received about failure of staff to knock before they entered a consumer’s room. They said staff were reminded of their responsibilities in relation to consumers’ privacy. Consumers reported that staff now knock and wait before entering their rooms.

Management were able to provide examples of complaints that had been received by the service and how these fed into the service’s plan for continuous improvement.

Staff meeting minutes reviewed by the Assessment Team evidenced that feedback from consumers and representatives is discussed and actioned to improve care and service delivery.

There are policies and procedures for the review of feedback and complaints and the actions that are required to be taken. If an improvement is identified from feedback that could potentially benefit consumers or result in system changes within the service, these are managed in line with policies and procedures and inform continuous quality improvement.

Management reported the following actions have been taken in response to the deficiencies previously identified under this requirement:

* The service has revised its policies and procedures in relation to the management of consumer feedback and complaints.
* Staff meetings are used to remind staff of the service’s policies and procedures, complaints processes and how to assist consumers to provide feedback in a confidential manner.
* Management explained and provided evidence that they trend complaints and feedback on a monthly basis and that this information is then provided to the Board for its acknowledgement and review.

For the reasons detailed above this requirement is compliant.

# STANDARD 8 Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Compliant

*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.*

The Assessment Team brought forward information in the assessment contact report demonstrating that effective organisation wide governance systems and processes were in place in respect to information management, continuous improvement, financial management and feedback and complaints.

Staff said they could access the information they required to deliver safe and quality care and services. An electronic care management system underpins care delivery and is accessible to staff and other health professionals. An online platform contains policies and procedures and changes to these are communicated to staff.

Consumers and representatives said they are provided with information that is timely and accurate and supports them to make informed decisions.

Management staff described the continuous improvement processes in place at the service and explained how improvement initiatives are drawn from a variety of sources including consumer feedback and complaints, analysis of clinical indicator data and incident data, and internal audits.

Management advised the governing body receives monthly consolidated reports from the various governance committees. This information is used to monitor the service’s compliance with the Aged Care Quality Standards and to initiate improvement actions to enhance the safety and quality of care.

The service has two financial officers on site and the Chief Executive Officer who has oversight of the budget. Management advised they have a monthly income and expenditure statement and meet with the executive on a monthly basis to discuss financial and operational matters. The Chief Executive Officer is responsible for managing the annual budget and management confirmed the organisation has been responsive to their budgetary requests.

Organisational systems and processes are in place to support and encourage consumers to provide feedback and make complaints. Appropriate action is taken in response to feedback and improvements are made.

At the time of the assessment contact, the Assessment Team found the organisation had previously implemented a number of improvements to strengthen its governance. These improvements included:

* Increased reporting to the Board that includes audits relating to call bell response times, medication management, restrictive practices, Workplace Health and Safety, safety inspections, and emergency responses.
* Strategic planning days have been scheduled to occur.
* The service has contracted an infection prevention and control lead.
* The service’s strategic plan has been updated and includes improvement initiatives for the service and projects that are occurring with the involvement of the management team and the Board.

The Assessment Team did however, bring forward deficiencies in relation to workforce governance and regulatory compliance. With respect to workforce governance, the organisation was not monitoring completion of staff training or ensuring that valid police checks were in place. With respect to documentation requirements associated with the Serious Incident Report Scheme, the service was not able to demonstrate that a consolidated register was in place. The assessment contact report states that management staff took immediate action to address these deficiencies including establishing a police check register and a training register and completing a consolidated register.

The approved provider in its response to the assessment contact report has revised the plan for continuous improvement and taken additional actions to address the deficiencies identied by the Assessment Team; evidence to support these improvements was submitted as an element of the response. Actions include but are not limited to:

* a police check audit has been completed and the register has been updated to reflect current information; all staff currently working have the required checks in place,
* an alert system has been established that will advise management of those police checks that are due for renewal in the near future,
* consolidation of mandatory training modules has occurred,
* an electronic program is used to document staff training records and now sends SMS amd email reminders to management and staff when training is due,
* additional registered nurse roles have been established and a new role is to be implemented that will provide additional support for the management team when they are on leave,
* there is increased monitoring of the completion of mandatory training and follow up occurs where required,
* mandatory training in the Serious Incident Response Scheme was conducted May 2022 and was supplemented by a staff eduation survey on the Serious Incident Response Scheme,
* the oritantion program for new staff now includes the electronic program used by the service to ensure staff know how to enter an incident.

For the reasons detailed above, I am satisfied that there are effective organisation wide governance systems and processes in place including in relation to workforce governance and regulatory compliance.

I find this requirement is compliant.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.