Performance

Report

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| Name of service: | Ozcare Palm Lodge |
| Service address: | 424 Bowen Terrace NEW FARM QLD 4005 |
| Commission ID: | 5918 |
| Approved provider: | Ozcare |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 August 2023 |
| Performance report date: | 20 September 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 Ozcare Palm Lodge (**the service**) has been prepared by K. Reed, 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 08 September 2023
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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.

* Consumers whose safety is at risk need to be monitored appropriately.
* Consumers subject to restrictive practices require consent and authorisation.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Consumers and representatives confirmed staff treated consumers with dignity and respect when providing care and services. Consumers confirmed staff knocked and asked permission before entering rooms and ensured personal care was delivered in private to ensure consumer dignity was maintained. Staff received mandatory and as required training on the principles of dignity and respect and cultural awareness. File reviews evidenced information pertaining to each consumers’ identity, culture and background were captured in care plans; cultural needs and preferences were reviewed and updated when required.

Clinical and care staff provided examples of how they provided care in a dignified and respectful manner. Staff promoted and valued each consumer’s culture, diverse background and identity.

Based on the information recorded above, this Requirement is Compliant.

# 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. | Non-compliant |

Findings

The changed behaviours of consumers have not been effectively managed to optimise the health and well-being of consumers. Safe and effective care was not provided to a consumer with suicidal intentions. All consumers subject to chemical restraint had not been identified and therefore did not have appropriate consent or authorisation. Behaviour support plans did not consistently contain individualised strategies to guide staff in managing the changed behaviours of consumers.

The Approved provider in its written response to the Assessment contact report has refuted some of the information contained in the report and has acknowledged there were gaps in the management of restrictive practices and improvement actions have been implemented to address these deficits.

For one named consumer, who displayed suicidal intentions on three occasions between April and July 2023, monitoring processes were not in place to determine the consumer’s location and referral to a dementia advisory service, older persons mental health service or psychologist had not occurred despite these recommendations being provided after the consumer attempted suicide in April 2023.

The Approved provider in its response has stated after each suicidal episode the above recommendations were discussed with the consumer’s medical officer and were declined on each occasion. I note the service has since referred the consumer to a dementia advisory service and included suggested strategies and interventions to the revised behaviour support plan submitted as part of the response.

While the consumer was monitored closely for a period of seven days following each episode of attempted suicide, there was no ongoing formal observation checks completed by staff to ensure the consumer’s safety. The Approved provider has responded to this statement by stating the ongoing monitoring of the consumer was outlined in their care plan as an ongoing strategy. I also note that following feedback provided at the Assessment contact, the consumer has been commenced on 30 minute visual observations and a sensor has been placed on both balcony doors to alert staff when the consumer is on the balcony areas.

While I acknowledge the actions the Approved provider has taken to monitor the consumer and to ensure behavioural strategies provide staff with guidance on managing the consumer’s behaviour, these actions have been taken in response to findings in the Assessment contact report and were not considered following the consumer’s first, second or third attempt at suicide. This does not support the consumer was receiving safe and effective personal and clinical care.

Assessment processes to identify consumers subjected to chemical restraint were flawed. Four consumers receiving psychotropic medication without a diagnosis matching the indications for usage were not identified by the service as being subject to chemical restraint. The Continuous improvement plan submitted by the Approved provider as part of the response confirms consent has been sought for these consumers following feedback at the Assessment contact, and education will be provided to staff relating to restrictive practice, to be completed by the end of September 2023. Retrospective incident reports were completed for these consumers and submitted to the Serious incident response scheme as inappropriate use of restrictive practices.

Behaviour support plans were recorded in the Assessment contact report as not containing individualised strategies to support consumers’ changing behaviours and did not consistently contain interventions suggested by specialist services following referral. The Approved provider in its response has acknowledged the auto-generation of assessment information can create lengthy care plans which can cause difficulty in locating relevant information to guide staff practice. The Approved provider has committed via the Continuous improvement plan a review of all behaviour support plans to ensure triggers and interventions for consumers’ changed behaviours are individualised and streamlined. Examples of refined behaviour support plans were included in the Approved provider response. While I note these revised care plans remain lengthy and contain repeated information, strategies were individualised and reflective of specialist advice where provided.

Information was contained in the Assessment contact report relating to consumers being prevented from leaving the service unaccompanied due to the geographical area of the service. The Approved provider has indicated this information was misinterpreted and provided examples of consumers who leave the service independently and have mobility plans to support their safety requirements when leaving the service. I consider the information provided in the response to be reasonable and appropriate to support consumers were supported to leave the service in line with their preferences.

I have considered other aspects of environmental restraint raised in the Assessment contact report are more appropriately considered under Requirement 5(3)(b).

In coming to my decision of Non-compliance in this Requirement I have placed weight on the evidence relating to the named consumer and their suicidal attempts and the lack of effective actions to monitor and prevent the reoccurrence of the consumer attempting to commit suicide. I have also considered assessment processes were ineffective at the service in identifying consumers subjected to chemical restraint.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

The Assessment contact report contains information that consumers were unable to move freely within and outside the service environment. Consumers and representatives provided feedback they could not move independently throughout the service. Staff stated consumers residing on level one of the service were unable to access the ground floor independently. A complex key was attached to the entry into a stairwell to promote the use of the lift rather that the stairwell.

The Approved provider has refuted information that consumers are prevented from accessing the ground floor or first floor. The Approved provider acknowledged the presence of a key in the door to the main stairwell, and noted the door was not locked, but for safety reasons it is the service’s preference to promote the use of the lift instead.

Following feedback provided during the Assessment contact the service has completed the following actions:

1. Reminded staff that consumers can and should access the lift if they would like to do so,
2. Reminded consumers through a newsletter and meeting they can access the lift if they would like to do so,
3. Placed a sign promoting the use of the lift of the lift, stairwell entry and in Wing E,
4. Further training will be undertaken with staff relating to restrictive practices.

The Continuous improvement plan submitted as part of the Approved provider’s response indicates a sign was in place providing instructions on how to open the door if consumers wished to use the stairs.

In coming to my decision of Compliance in this requirement, I considered there were processes in place to allow consumers to move freely inside and outside the service.

# 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 had systems in place to ensure the right number and mix of staff were allocated to all areas of the service, including the Memory support unit, to enable the delivery of quality care and services to consumers. Management allocated shifts to areas where there was an identified need and were proactive in recruiting staff prior to staff going on long periods of leave to mitigate risks to the provision of care and services.

Consumer and representatives provided feedback there was sufficient staff to deliver services and answer requests for assistance. Staff provided feedback additional staffing that commenced in August 2023, has improved the ability of staff to provide care and services.

Call bell data was regularly reviewed, and analysis identified the call bells were responded to within policy timeframes.

A rolling roster of permanent staff members and organisation casual and permanent staff were used to fill shifts prior to the use of temporary staff.

Based on the information above, this Requirement is Compliant.

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)