Performance

Report

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| Name: | Stroud Community Lodge |
| Commission ID: | 0283 |
| Address: | 51-53 Cowper Street, STROUD, New South Wales, 2425 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 5 October 2023 |
| Performance report date: | 9 November 2023 |
| Service included in this assessment: | Provider: 258 Stroud Community Lodge Inc  Service: 299 Stroud Community Lodge |

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 Stroud Community Lodge (**the service**) has been prepared by G Cherry, 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
* the provider’s response to the assessment team’s report received 19 October 2023
* Performance Report dated 28 April 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 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 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 |

Findings

The Quality Standard was not fully assessed. One requirement was assessed and found compliant.

Previously the service did not demonstrate completion of comprehensive risk assessment for consumers deemed to require restrictive practice such as psychotropic medication and/or experienced falls. Via review of plan for continuous improvement (PCI), responsive actions include updating of clinical pathway and guidelines for post-fall documentation and an audit of files relating to neurological observations chart, clinical pathway, and post falls guidelines.

While general risks are considered during the assessment and planning process, specific risks related to each consumer are not identified and documented. Organisational policies/procedures provide guidance in relation to conducting assessments, however via document review the assessment team not the service does not demonstrate an effective system to ensure consideration of risks in regular assessment/planning to inform delivery of safe/effective consumer care. Reassessment of consumer's risks post hospitalisation, including implementation of hospital discharge care directives, nor medical officer review are not evident.

Via review of documentation for 3 consumers (who had experienced falls) the assessment team bought forward evidence neurological observations, pain assessment/monitoring, blood glucose level (BGLs) monitoring, physiotherapy/mobility and/or medical officer review not consistently documented to guide staff in consumer’s required care post fall. Documentation for another consumer did not detail risks (including mitigating strategies) associated with fluid restriction directives to guide staff in care delivery.

In their response, the approved provider supplied evidence of pain assessment, neurological observations, medical officer review, including directives to cease monitoring as per consumer’s choice. While noting a lack of documented directives for one consumer, they attribute this to software malfunction, supplying evidence information was recorded however did not transfer. In consideration of compliance, I accept this evidence. I find requirement 2(3)(a) is compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |

Findings

The Quality Standard was not fully assessed. One requirement was assessed and found compliant.

Previously the service did not demonstrate timely response to deterioration or change in consumers’ condition, including neurological observations for consumers experiencing a fall, or timely hospital transfer. Responsive actions include development of relevant policy and staff education in relation to identification of deterioration.

Most sampled consumers/representatives’ express satisfaction of clinical care and staff interaction. However, an effective system to ensure staff respond to triggers/changes and escalate issues of concern when consumers experience deterioration and/or document routine care observations to demonstrate appropriate care delivery. While staff demonstrate knowledge of processes relating to escalating changes in consumers' conditions, via document review of 3 consumers files the assessment team note the service did not demonstrate registered nurse responsiveness and/or further escalation to medical officer occurs in a timely manner.

In their response, the approved provider supplied evidence of pain assessment, neurological observations, medical officer review/directives as per consumer’s choice. While noting a lack of documented directives for one consumer, attribute this to software malfunction, supplying evidence information was recorded. In consideration of compliance, I accept the approved provider’s evidence to support deterioration/change in consumer’s condition is recognised and responded to as per consumer’s needs and wishes and am swayed by satisfaction expressed by consumers/representatives. I find requirement 3(3)(d) is 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 Quality Standard was not fully assessed. One requirement was assessed and found compliant.

Previously the service did not demonstrate effective governance systems relating to information management. Although policies/procedures package had been purchased, modification and subsequent approval and staff training had not occurred resulting in inconsistencies of staff practice. Responsive actions include completion of policy/procedural documentation, staff learning modules and discussion at team meetings and performance appraisals linked to training modules.

A suite of organisationally tailored policies and procedures reflective of service circumstances are accessible to provide staff guidance. Interviewed staff demonstrate awareness of these documentation to find guidance, noting discussions occur at meeting forums and regular training/education reflective of their role and responsibilities. The assessment team note staff not consistently adhering to some policies/procedures [considered in requirements 2(3)(a) and 3(3)(d)]. The organisation uses feedback systems and consumer forums to identify and implement improvement activities. A process ensures regular transfer of information to board members, relating to care delivery and document review demonstrate active involvement by board members. An annual budget at service level drives purchases and board involvement occurs for additional purchases deemed necessary such as recently purchase of furniture and roof replacement. Management have access to appropriate funding to purchase items to support consumer care and service delivery. Sampled consumers/representatives consider appropriate supplies and equipment availability. Documentation review and board member/management interview demonstrate awareness of local workforce challenges and actions (including an increase in staffing) taken to address this. Interviewed staff note sufficient staff numbers and a process to ensure minimal consumer impact when unplanned leave occurs. Processes ensure registered nurse availability when not on site. Updates from peak governing bodies ensure board awareness of legislative changes/requirements and management have responsibility to maintain compliance. Staff receive education/updates on sector changes including Serious Incident Response Scheme reporting requirements. Governing body oversight occurs relating to consumer feedback and complaints. Management demonstrates development of a governance framework, policies/procedures to support safe, inclusive, quality care and services.

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)