Performance

Report

**1800 951 822**

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| Name of service: | The Sydney-Lynne Quayle & Fitzroy Lodge Hostels |
| Service address: | 21 Barclay Street HEYWOOD VIC 3304 |
| Commission ID: | 3354 |
| Approved provider: | Heywood Rural Health |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 17 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 The Sydney-Lynne Quayle & Fitzroy Lodge Hostels (**the service**) has been prepared by N Chahal, 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 7 August 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 4** Services and supports for daily living | **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 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 |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The service was found Non-compliant in Standard 2 in relation to Requirements 2(3)(a) and 2(3)(e) following a site audit in September 2022 where it was unable to demonstrate:

* assessment and care planning considered current risks to consumers’ health and well-being. Care documentation did not always describe strategies to mitigate risks in relation to falls, seizures, changed behaviours, and restrictive practices.
* effective review of care and services when consumers had experienced an incident or change in their health and well-being, including in relation to changed behaviours and falls.

At the July 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives were satisfied they are involved in assessment and planning and that risks are considered to inform safe care in relation to falls, seizure management, changed behaviours, and restrictive practices. Staff demonstrated knowledge of high impact risks in relation to individualised consumer care needs and explained how these risks are assessed, planned and considered when developing specialised nursing care plans. Care planning documentation recorded potential and identified risks and risk mitigation strategies for risk associated with falls management, pain management, changed behaviours, restrictive practices, and management of seizures. The Assessment Team observed a daily planner board and handover sheets guiding staff on a consumer’s individualised risks in line with care planning documents.

Consumers and representatives were satisfied the service effectively reviews care and services following an incident or change in a consumer’s health or well-being. Staff demonstrated a systematic approach to the review of care following an incident or when a consumer’s circumstances change. Staff described the use of post fall and skin integrity checklists to manage and report incidents. Care documentation demonstrated the involvement of medical practitioners and allied health professionals following a change in a consumers care needs. Care plans and risk assessments are regularly reviewed for effectiveness during the 3-monthly evaluation and when changes to health and well-being occur including pain management, falls management, and changed behaviours. The Assessment Team observed the behaviour support plans and psychotropic register for 2 consumers did not outline the specific medications of restraint. In response to feedback, management immediately rectified this deficit during the Assessment Contact.

Based on the available evidence, I find Requirements 2(3)(a) and 2(3)(e) are 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The service was found Non-compliant in Standard 3 in relation to Requirements 3(3)(a) and 3(3)(b) following a site audit in September 2022 where it was unable to demonstrate:

* effective identification, monitoring, and review in relation to the use of chemical restraint and other prescribed psychotropic medications.
* effective management of falls and seizures for high-risk consumers

At the July 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits in relation to Requirement 3(3)(b). However, the Assessment Team identified ongoing deficits in relation to Requirement 3(3)(a) regarding chemical restraint.

I have considered the Assessment Team’s findings, the evidence in the site audit report, and the Approved Provider’s response in relation to Requirement 3(3)(a) and have come to a different view:

Requirement 3(3)(a)

The Assessment Team found the service was unable to consistently demonstrate accurate identification of chemical restraint and provide evidence of informed consent. The Assessment Team’s evidence related to two consumers and included deficits in the documentation of informed consent and identification of chemical restraint in the behaviour support plans and the psychotropic register. Staff demonstrated the use of chemical restraint is a last resort when non-pharmacological strategies are ineffective. The Assessment Team noted that the review and monitoring of prescribed psychotropic medications occurs and minimisation strategies are employed. Representatives were satisfied with the care and services provided to consumers, providing positive feedback about being involved in discussions about psychotropic medications.

The Approved Provider submitted a written response with clarifying information and documentation including progress notes, care plans, flowcharts, policies, and self-assessment tools.

In response to the deficits identified in relation to the two named consumers, the Approved Provider submitted evidence demonstrating that for one named consumer the service had identified the use of psychotropic medication as a chemical restraint in their behaviour support plan and related informed consent was documented prior to the Assessment Contact. For the other named consumer, the service evidenced that the behaviour support plan was updated, and informed consent was obtained during the Assessment Contact. Progress notes and care plan documentation submitted by the Approved Provider further supported ongoing consultation with the consumer and representatives and an improvement in documentation practices.

The Approved Provider has further identified opportunities for improvement relating to documentation deficits including revision of policies and informed consent forms relating to restrictive practices, involvement of pharmacy consultant services, and planned education for staff. In relation to the psychotropic register, the provider outlined that a review has been undertaken and an audit tool has been created to evaluate and monitor compliance.

I have reviewed all of the information provided. While I acknowledge there was some deficits in documentation, I am satisfied the Approved Provider has demonstrated it has effective systems in place to ensure consumers receive safe and effective care in relation to restrictive practices. I encourage the Approved Provider to continue embedding these improvements into usual practice. Therefore, I find this requirement is Compliant.

Requirement 3(3)(b)

The service demonstrated effective improvement had been made to processes in relation to post-falls and seizure management, particularly in relation to neurological observations. Representatives confirmed satisfaction with the services management of high impact and high prevalence risks associated with falls and seizures. Staff demonstrated an understanding of individual consumer risks and outlined that post-incident checklists are used to ensure incident management is in line with best practice and organisational policies and procedures. Staff discussed using a ‘critical thinking strategy’ which involves collaboration between staff to discuss consumers holistic care needs. Care documentation including specialised nursing care plans and post-incident checklists demonstrated that organisational procedures are followed to effectively manage high impact and high prevalence risks relating to falls and seizure management.

Based on the available evidence, I find Requirement 3(3)(b) is Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service was found Non-compliant in Standard 4 in relation to Requirement 4(3)(f) following a site audit in September 2022 where it was unable to demonstrate that meals of sufficient quality are provided to adequately support consumers’ nutrition and dietary needs.

At the July 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives were satisfied the service provided enjoyable, good quality meals and catered to their preferences. Staff said consumers are provided with menu choices and confirmed that alternative meals are offered if the consumer was not satisfied with the meal served. Menu choice forms demonstrated that consumers can request a range of alternative meals where they prefer another option to the menu options being offered. Staff provided example of how modified meals are plated to look appealing when serving to individual consumers in line with their documented preferences. The service offers a 5-weekly rotating menu reviewed by a dietitian. The Assessment Team observed meals served are consistent with the displayed menu options, meals are visually appealing and smelled enticing, and no discretionary foods such as party pies or fish fingers were observed on the menu.

Based on the available evidence, I find Requirement 4(3)(f) is Compliant.

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)