Performance

Report

**1800 951 822**

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| Name of service: | Yallambee Lodge |
| Service address: | 1 Binalong Street COOMA NSW 2630 |
| Commission ID: | 0352 |
| Approved provider: | Snowy Monaro Regional Council |
| Activity type: | Assessment Contact - Site |
| Activity date: | 5 July 2023 |
| Performance report date: | 4 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 Yallambee Lodge (**the service**) has been prepared by M Roach, 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 and consumers/representatives
* the approved provider’s response to the assessment team’s report received on 22 August 2023
* the provider’s compliance history against the Quality Standards in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | **Non-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.

Requirement 8(3)(d) – the provider ensures effective risk management systems and practices:

* to manage consumers’ high impact and high prevalence risks including consistent assessment and documentation regarding restrictive practice and behaviour support
* to ensure appropriate response to Serious Incident Response Scheme incidents including timely reporting and effective investigation to prevent similar incident from occurring and to drive continuous improvement.

# Other relevant matters:

* The assessment contact was completed by an assessment team of Quality Assessors and accompanied by an Authorised Officer. Whilst the Authorised Officer was measuring the provider’s practice against the *Quality of Care Principles 2014*, I have considered relevant information gathered by the Authorised Officer relating to restrictive practice and behaviour support in the context of the Quality Standards’ intent, as part of the assessment team’s report, when preparing this performance report under relevant Requirements.
* The approved provider in its response to the assessment team’s report outlined a number of externally impacting factors which include a recent incident that attracted significant media attention. While I acknowledge the potential additional scrutiny placed upon the service by the media as identified by the service in their response, this specific incident and associated media coverage was not considered as relevant information or influenced my view when preparing this performance report.

# 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)(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

Requirement 3(3)(a)

The assessment team sampled approximately 30% of the consumers and representatives and a vast majority of interviewed consumers and representatives provided positive feedback about the clinical and personal care consumers receive. Through a sample of consumers with complex care needs, the assessment team identified clinical care in some areas was well managed, tailored to consumers’ needs and optimising consumers’ health and well-being. This includes safe and effective care delivery in the management of consumers’ continence needs, falls and fall’s risk, skin care, complex wounds, diabetes, pain and weight loss. Management and staff showed a shared understanding of sampled consumers’ care needs and preferences and described strategies to support tailored care delivery that is consistent with the consumers’ care planning documents.

In relation to the management of consumers’ behaviours including restrictive practice, the assessment team report included information on:

* The service utilises multiple restraint related forms and for 2 consumers there are inconsistent documentation for the purpose of the restraint practice.
* Restrictive practice related policy and procedures are informed by legislative requirements however lack some of required details in accordance with the *Quality of Care Principles 2014*.
* The service’s informed consent documentation for restraint did not show evidence that the information required to inform the consent had been explained to consumers and representatives providing consent.
* There is limited information to support restrictive practice are being used as a last resort and progress notes for sampled consumers did not show best practice alternatives strategies before a restrictive practice is used.
* Consumers’ care plan and behaviour support plan include generalised and non-specific strategies.
* An event where appropriate person-centred behaviour support was not provided to a consumer when they were experiencing changed behaviour.
* The provider did not meet mandatory Serious Incident Response Scheme (SIRS) notification for an incident occurred in May 2023.

The provider in its response to the assessment team’s report acknowledged deficits relating to inconsistent documentation and explained the limitation regarding documentation in their electronic document system (this is further discussed in Standard 8 Requirement 8(3)(d)). The provider also stated they will review and update their procedures based on the feedback provided. However, the provider refuted other deficits identified and included the below evidence to demonstrate the service delivers safe and effective person-centred care including behaviour management.

* A description of restraint consent discussion and documentation process. Multiple written communication between the service and consumers’ representatives that include information on the medication to be used as a chemical restraint, why it was to be used, the dosage and frequency of the medication to be used, possible side effects and potential risks associate with the medication, health practitioner’s approval, prescribing date, medical review frequency and the next planned review date.
* A sample of psychotropic intervention acknowledgement and consent documentation and family case conference information that included unsuccessful non-pharmacological interventions have been used to try to manage a consumer’s behaviour before chemical restraint was considered and prescribed.
* A sample of medical records and progress notes that evidence ongoing consultation with consumer’s representative and medical practitioner for the purpose of monitoring and evaluating restraint usage.
* A sample of a consumer’s behaviour support plan which include: a detailed portrait of the consumer’s past and current life, personal preference and things they enjoy doing; planned outcome and 3 tier of interventions to guide staff practice when supporting the consumer’s behaviour needs.
* A full explanation of the event supported by progress notes to evidence the concerns raised was a misinterpretation of a specific progress note entry, person-centred care was delivered when the consumer experienced changed behaviour, the care was in line with the consumer’s behaviour support strategies and unmet needs had been managed.
* Detailed information on the consumer who was involved in the SIRS incident including complex life experience and clinical background, the management strategies the service utilised for the consumer’s behaviour and care needs which was developed in consultation with the consumer’s medical practitioner, representatives and external behaviour support specialist.
* A consumer representative’s statement that has detailed information on their satisfaction on the tailored personal and clinical care delivery at the service, including the management of consumers’ health decline, changed behaviour, chemical restraint and associated risk. The statement confirmed the restraint consent discussion and documentation process describe by the provider, non-pharmacological interventions have been implemented however were unsuccessful before chemical restraint was considered, the representative had received all required information when providing consent and the chemical restraint is being continuously monitored for its effectiveness and in consultation with medical practitioner and representatives.

Both the assessment team’s report and the provider’s response included information on the continuous improvement actions the provider is undertaking, including:

* The ongoing delivery of dementia care, behaviour support and incident reporting training to staff.
* Updated orientation and induction program to include behaviour support procedures, plans, intervention and documentation for new staff commencing from 1 July 2023.
* The ongoing review of behaviour support plans for all consumers, in partnership with the consumer/ representatives, to ensure the capture of all information to best support consumers through their journeys.
* A review of all consumers who are subject to restrictive practice commenced in July 2023.

In considering relevant information from the assessment team report and the provider’s response, whilst I acknowledge the deficits included in the assessment team’s report relating to restraint and behaviour support documentation which is further discussed in Standard 8 Requirement 8(3)(d), I was persuaded by the provider’s detailed response with supporting evidence which is corroborated with the representative’s statement regarding the delivery of person-centred behaviour management including use of restrictive practice. I also place weight on the many clinical and personal care areas that were well managed, tailored to consumers’ needs and optimising consumers’ health and well-being. This includes the safe and effective management of consumers’ continence needs, falls and fall’s risk, skin care, complex wounds, diabetes, pain and weight loss. Further, the provider’s response and the service’s compliance history showed their willingness and ability to work with consumers and representatives to implement continuous improvement to deliver better restraint management and behaviour support.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(a) compliant.

Requirement 3(3)(d)

Most representatives of sampled consumers provided positive feedback about the service’s timely and effective response to deterioration in the consumers’ condition. Representatives stated the service provide timely information on recognising and managing changes or deterioration in consumer’s health or function. Care plans and progress notes generally reflected the timely identification, monitoring and response to consumers’ changed condition including weight loss, changed behaviour, mobility decline/ falls, increased pain, cognitive decline and general deterioration. Management and care staff showed understanding of sampled consumers’ deteriorating functions and described how they identify and escalate concerns, work with external health providers including medical specialists to meet individual consumers’ care needs and goals.

Management team described the challenges faced by the service in accessing health care specialists in their regional area and the impact this has had on timely medical review of consumer’s changed condition, despite their best efforts. However, the service demonstrated it has taken steps to successfully access specialist services such as palliative care, dementia and behaviour support and virtual dietician service to manage consumer deterioration. The service has improved and increased staff training in areas involving management of consumers’ changed condition or deterioration. This includes behaviour support and dementia care.

The assessment team brough forward a named consumer’s experience where there have been deficits identified relating to the management of cognitive and behavioural functioning change. The provider in its response to the assessment team’s report acknowledged a level of delay in referring the consumer to external behaviour support specialist. The response also provided information and evidence to demonstrate the management of the consumer’s deterioration, including timely recognition of changed condition, regular and additional consultation with the medical practitioner, ongoing collaboration with the consumer and their representatives, usage of individualised strategies to support the consumer’s emotional and psychological wellbeing, referral to an external behaviour support specialist and implementation of recommended interventions. Whilst I acknowledge there was a delay in the specialist referral process, there was little information provided in the assessment team report indicating the actual or potential harm to the consumer caused by the delayed referral. I also noted that the consumer was reviewed by the external behaviour support specialist on the day of the assessment contact and the service is further training staff on how to best support this consumer’s complex needs. Consequently, the risk associate with the delayed referral was mitigated. As such, I was persuaded that the consumer’s cognitive and behavioural change was recognised in a timely manner and generally managed.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(d) compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Non-compliant |

Findings

The assessment team found the organisation demonstrated effective risk management systems and practices in relation to the management of high impact, high prevalence risks associated with consumers’ care, supporting residents to live their best life, and managing and preventing incidents, including the use of its incident management system. However, I have relied upon evidence included under Requirement 3(3)(a) regarding inconsistent or incomplete restrictive practice and behaviour support documentation and the provider’s response which demonstrated the organisation’s risk management systems and practices is not managing all high impact or high prevalence risks associated with the care of consumers.

Whilst the organisation has restrictive practice related policy and procedures in place which are informed by legislative requirements, the procedures lacked required details to guide staff practice especially documentation in accordance with the *Quality of Care Principles 2014* – Part 4A Behaviour support and restrictive practice. In addition, the electronic documentation system the service uses has its limitation to enable comprehensive assessment, monitoring and documentation associated with restrictive practice and behaviour support. I acknowledge the provider had identified the documentation gap and is taking continuous improvement actions including review and update restrictive practice policies and procedures, review all consumers’ behaviour support plans and restraint documentation, deliver ongoing training to staff and liaise with electronic documentation system developer to improve the software by updating individual assessment or forms. I was not provided sufficient evidence to be satisfied that the organisation has addressed all of the deficiencies identified, including having an effective system to identify and address issues that affect or may affect the effective management of consumers’ high impact or high prevalence risks, review outcomes and adjust staff practice. The provider is still undertaking improvements and I encourage them to embed these improvements into their usual practice to ensure all consumers’ high impact and high prevalence risks, including restrictive practice and behaviour support, are managed appropriately and documented consistently.

The assessment team identified the provider’s risk management systems and practices did not always identify and respond to abuse and neglect of consumers. This is evidenced by the provider did not meet mandatory Serious Incident Response Scheme (SIRS) notification and reporting requirements for a Priority 1 notifiable incident occurred in May 2023, there were gaps in the service’s internal incident investigation and reporting in relation to the notifiable incident and the internal investigation remains incomplete 2 months following the incident. The provider in its response to the assessment team’s report refuted the deficits relating to the unreported SIRS notification and its investigation process. The provider gave information on the consumer’s complex clinical background, how the service managed the consumer’s behaviour and care needs and provided file notes to demonstrate the internal investigating process. Although I acknowledge the provider delivered clinical assessment, has undertook appropriate remedial actions and provided emotional support to the affected parties following the alleged Priority 1 incident, I was not provided sufficient evidence to be satisfied the provider’s action regarding their decision not to report the alleged Priority 1 incident was consistent with the legislative requirement or the organisations’ SIRS management procedure. In addition, I was not provided evidence to be persuaded that the internal investigation had been finalised, more than 100 days post the alleged incident, to prevent similar incident from occurring and to drive continuous improvement.

Based on the evidence and reasons detailed above, I find Requirement 8(3)(d) non-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)