Copperhouse Court Hostel

Performance Report

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**Commission ID:** 6155

**Provider name:** Kindred Living (Formally Whyalla Aged Care Inc)

**Assessment Contact - Site date:** 18 November 2020

**Date of Performance Report:** 5 February 2021

# Publication of report

This Performance Report **may 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

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(b) | Compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(c) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commission’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 consumers, staff and management
* the Performance Report for the Site Audit conducted 4 December 2019 to 5 December 2019.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team assessed Requirement (3)(b) in relation to Standard 2. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 4 December 2019 to 5 December 2019.

In response to the Site Audit, the Decision Maker found the service did not have effective processes to assist staff to identify when two consumers entered the terminal phase of life or to support the development of a relevant care plan during this period. The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 2 Requirement (3)(b) and find the service Compliant with Requirement (3)(b). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit conducted 4 December 2019 to 5 December 2019, including:

* Adopted an End of Life Care Pathway which has been used for consumers identified as requiring palliative care or nearing end of life.
* The Assessment Team observed this documented had been completed for the three sampled consumers.
* Reviewed/developed palliative care policies, procedures and guidelines. Staff interviewed were aware of how to access such policies and confirmed they were useful.
* Provided training and tools to staff through meeting forums and training days to assist in identifying the terminal phase of life.
* Created an ‘End of Life Care Plan’ template to enable staff to capture consumers’ end of life needs, goals and preferences and to guide staff practice.
* Reviewed and updated templates for ‘pre-admission assessment’ and ‘admission assessment’ to include end of life wishes, funeral arrangements and whether an advance care directive was in place.
* Updated the ‘Resident Guide’, provided to consumers on entry to include a section titled ‘Thinking Ahead’. This includes information and further resources related to end of life choices and advance care directives.

In relation to Standard 2 Requirement (3)(b), documentation viewed, observations, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

Care planning documents viewed for sampled consumers included individualised needs, goals and preferences. End of life wishes were clearly documented on each consumer’s profile page. Care files viewed for three consumers who had recently passed demonstrated the service had adequately utilised assessment processes and new palliative care/end of life templates to identify consumers’ end of life needs, goals and preferences.

Consumers interviewed reported the service had identified their needs, goals and preferences from assessment and care planning processes and confirmed staff were knowledgeable and respectful of their expressed preferences. Additionally, consumers confirmed they had been asked about their end of life wishes and had completed an advance care directive.

Staff interviewed were knowledgeable about the consumers sampled and described how they provide personal and clinical care in line with consumers’ needs, goals and preferences. Clinical staff were knowledgeable of assessment processes and described how and when the end of life pathway and palliative care plan is initiated. Staff were aware of how to access policies, procedures and guidelines in relation to palliative care and confirmed they were useful.

The Assessment Team’s report demonstrated the service has monitoring processes to ensure assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

For the reasons detailed above, I find the approved provider, in relation to Copperhouse Court Hostel, Compliant with Requirement (3)(b) in Standard 2.

# 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

The Assessment Team assessed Requirement (3)(c) in relation to Standard 3. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 4 December 2019 to 5 December 2019.

In response to the Site Audit, the Decision Maker found the service did not have effective assessment or monitoring processes to ensure two consumers’ end of life needs, goals and preferences were recognised, their comfort maximised, or their dignity preserved. The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 3 Requirement (3)(c) and find the service Compliant with Requirement (3)(c). I have provided reasons for my finding in the specific Requirement below.

### Assessment of Standard 3 Requirements

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit conducted 4 December 2019 to 5 December 2019, including:

* Provided training to staff to assist them in identifying the terminal phase of life and ensuring palliative consumers’ comfort is maximised and dignity preserved.
* Adopted an End of Life Pathway which has been used for consumers identified as requiring palliative care or nearing end of life.
* The Assessment Team observed this document had been completed for the three sampled consumers.
* Reviewed/developed its palliative care policies, procedures and guidelines.
* Created an ‘End of Life Care Plan’ template to enable staff to capture consumer end of life needs, goals and preferences and guide practice.
* Sampled care files viewed demonstrated care had been delivered in line with consumers’ documented needs, goals and preferences.
* Implemented a palliative care shift documentation form which is completed by staff each shift. This automatically populates an entry in progress notes to summarise care provided and enables senior clinical staff to provide ongoing monitoring of care delivery, comfort and well-being of consumers in end of life.
* The form was observed to be in use by the Assessment Team and was reflected in progress notes.
* Commenced monthly Resident of the Day reviews.

In relation to Standard 3 Requirement (3)(c), documentation viewed, and information provided to the Assessment Team by staff through interviews demonstrated:

Consumer files sampled for three consumers who had recently passed demonstrated their needs, goals and preferences had been recognised and addressed, their comfort maximised, and dignity preserved. Documentation demonstrated End of life pathways had been initiated, emotional support was provided, pain was frequently monitored, and family were kept updated.

Comments and complaints records viewed by the Assessment Team demonstrated representatives had been complimentary about the care and services provided to consumers during the palliative phase.

Clinical and care staff interviewed described how the delivery of care and services is altered to ensure the needs, goals and preferences of consumers nearing the end of life are addressed. Staff also discussed how hey ensure care is provided in a way which promotes privacy, dignity and respect.

The Assessment Team’s report demonstrated the service has monitoring processes to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

For the reasons detailed above, I find the approved provider, in relation to Copperhouse Court Hostel, Compliant with Requirement (3)(c) in Standard 3.

# 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

The Assessment Team assessed Requirement (3)(e) in relation to Standard 8. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(e) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 4 December 2019 to 5 December 2019.

In response to the Site Audit, the Decision Maker found the service had not effectively implemented the changes to the *Quality of Care Principles 2014* in relation to use of chemical restraint. The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 8 Requirement (3)(e) and find the service Compliant with Requirement (3)(e). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(e) Compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit conducted 4 December 2019 to 5 December 2019, including:

* Updated a range of policies and procedures, including in relation to physical and chemical restraint, assessment, authorisation, observation and review.
* Policies and procedures reflect the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019.
* Implemented a monthly Chemical restraint/psychotropic audit which monitors consumers who have prescribed chemical restraints/psychotropic medications and processes to ensure there are appropriate medical orders, assessments and review processes.
* Implemented a three monthly antipsychotic review form for consumers who are being administered psychotropic medications.
* Developed a Record of consumers receiving psychotropic medications which is updated monthly.
* Developed a Restraint folder containing all relevant information in relation to physical and chemical restraints.
* Updated the Admission assessment and implemented a new Pre-admission assessment to reflect the capturing of information in relation to psychotropic medication.
* Reviewed the care plan review and care consultation form to include a prompt in relation to medication management and in particular psychotropic medication changes and reviews.

In relation to Standard 8 Requirement (3)(e), documentation viewed and information provided to the Assessment Team by management and staff through interviews demonstrated:

Minimising use of restraint

Care files viewed for three consumers receiving chemical restraint demonstrated Psychotropic medication review forms have been completed in consultation with Medical officers.

Completed three monthly antipsychotic review forms viewed for a number of consumers confirmed the service is monitoring and reviewing the usage of psychotropic medications.

The monthly clinical indicator report viewed by the Assessment Team demonstrated restraint use is monitored through a range of forums both at a service level and organisationally.

Clinical staff interviewed were aware of their responsibilities in relation to recording and monitoring physical and chemical restraints and monitoring of psychotropic medication usage.

Antimicrobial stewardship

There are policies and procedures which outline principles of antimicrobial stewardship.

Clinical staff could describe the concepts of antimicrobial stewardship and how they incorporate this into their practice, such as increased monitoring of consumers who are at risk of urinary tract infections.

Infection data and use of antibiotics are monitored through a range of forums both at a service level and organisationally.

Open disclosure

The organisation has policies relating to open disclosure and staff were aware of the policies and provided examples relevant to their roles.

Management described examples of where open disclosure processes had been applied, including for a medication incident involving a consumer.

For the reasons detailed above, I find the approved provider, in relation to Copperhouse Court Hostel, Compliant with Requirement (3)(e) in Standard 8.

# 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.