Eldercare The Lodge

Performance Report

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**Commission ID:** 6184

**Provider name:** Eldercare Inc

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

**Date of Performance Report:** 27 July 2020

# 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 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(b) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(d) | 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 staff, consumers, representatives and others.
* the provider’s response to the Assessment Contact - Site report received on 7 July 2020.

# STANDARD 3 COMPLIANTPersonal 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 Quality Standard is assessed as Compliant as one of the seven specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

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 an Assessment Contact conducted on 5 December 2019.

The Assessment Team recommended Requirement (3)(b) in Standard 3 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report, and the approved provider’s response to come to a view of compliance with Standard 3 and find the service is Compliant with Requirement (3)(b).

At an Assessment Contact – Site 5 December 2019, in relation to Standard 3, Requirement (3)(b), the Decision Maker found the service did not adequately assess or support consumers’ high impact or high prevalence risks associated with the care of each consumer, specifically in relation to diabetic management and medication management. The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

### Assessment of Standard 3 Requirements

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

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the last Assessment Contact – Site, including:

* All diabetic consumers have been reviewed under a new diabetes management procedure and plan. This has included a review of all diabetic management plans and information regarding dietary preferences and snacks.
* A diabetic management audit was completed in January 2020 and actions have been documented as completed.
* Clinical staff said the new sick day management section of the diabetic plan was helpful in providing additional management guidance.
* The organisation’s Medication management policy has been updated. The new policy incorporates all aspects of medication management and replaces the previous Medication administration policy. The service has implemented a system which is consistent with processes across all of the organisation’s sites. Memoranda have been disseminated to staff, for example, with information on the after hours pharmacy, to assist staff to access medication outside of the impress system.
* The service conducted a medication audit in December 2019 and actions were completed in March 2020. The service is proposing a repeat audit following implementation of actions to improve their system and performance.
* The service has introduced daily buzz meetings between clinical management, nursing and care staff. This has assisted in raising staff awareness of skin integrity for consumers, including having skin integrity risk assessments and care plans with strategies to maintain skin integrity through pressure area care.
* Staff said they received education relevant to their role and described how this assists them to provide care to consumers. Training has included dementia care, medication management, skin and wound management, and incident reporting.

The approved provider’s response demonstrated they agreed with the Assessment Team’s findings.

In relation to Standard 3 Requirement (3)(b), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives interviewed considered that consumers receive personal and clinical care that is safe and right for them. This includes having access to timely medical services when required.
* One representative was not satisfied with the care and services provided by staff. Management provided additional information on the assistance provided by staff, including monitoring strategies, for support the well-being of the consumer.
* The service has assessment and planning processes which commence on admission and include six-monthy reviews, or more frequent reviews if required.
* The service has a risk management policy and processes in place to manage high impact and high prevalence risks through identification, care planning and monitoring.
* The service has introduced a malnutrition screening tool to identify consumers at risk. All consumers have been assessed using this tool and strategies put in place in response to individual consumer’s requirements.
* The service has processes to refer consumers to external health providers as required.
* The service manages high clinical risks to consumers through daily morning catch up meetings between clinical, nursing and care staff. Information from the morning meeting is handed over to afternoon shifts.
* A Multi Disciplinary meeting is held weekly where individual consumer’s needs and preferences are discussed and additional strategies are identified and implemented.
* Clinical managers complete a monthly report to the Site manager on falls, weights, challenging behaviours, wounds, infections and audit results. This information is disseminated to clinical and care staff to provide them with information on clinical outcomes for consumers.
* The Site manager communicates clinical risk information to the Head office executive who will escalate matters to the Board as necessary.

For the reasons detailed above, I find the approved provider, in relation to Eldercare The Lodge, does comply with Requirement (3)(b) of Standard 3.

# STANDARD 7 COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Compliant as one of the five specific Requirements have been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

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

The Assessment Team recommended Requirement (3)(a) in Standard 7 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report, and the approved provider’s response to come to a view of compliance with Standard 7 and find the service is Compliant with Requirement (3)(a).

At an Assessment Contact – Site 5 December 2019, in relation to Standard 7, Requirement (3)(a), the Decision Maker found the service was unable to demonstrate that the workforce is planned to enable, and the number and mix of members of the workforce enables, the delivery and management of safe and quality care and services. The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the last Assessment Contact – Site, including

* The service has reviewed and changed the duty statements for Enrolled nurses working in the Memory Support Unit (MSU). The implemented change ensures the presence of an Enrolled nurse in the MSU during lunchtime to monitor consumers at risk.
* A lifestyle staff member is now rostered in the MSU from 9.45am to 8.00pm daily.
* The service has refocussed the tasks of the lifestyle staff in the MSU to ensure they are monitoring and are available for consumers at high risk, including those with known behaviours and at risk of falls.
* A discussion group for staff working in the MSU has been established, with the aim of identifying strategies to ensure delivery of care and services to consumers. The focus group includes a staff member from the organisation’s Dementia Excellence program. The minutes of the focus group meeting held on 24 March 2020 reflected a range of ideas which may be considered for implementation.
* Call bell data is monitored and analysed monthly by the Clinical care manager. A new Call bell reflective practice process for staff has been introduced for call bell response times over 10 minutes. This process includes follow-up with consumers and/or representatives about the event and a formal apology.
* To assist with the monitoring of staff attendance to call bells to respond to consumer’s needs, the service has varied the Enrolled nurses’ call bell alerts to their DECT phones to register at three minutes rather than five minutes. Staff said this change has improved call bell response times as the Enrolled nurse is notified when staff may require assistance.
* The service is continuing to recruit new staff to cover permanent vacant shifts on the roster.

The approved provider’s response demonstrated they agreed with the Assessment Team’s findings.

In relation to Standard 7 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Overall consumers and representatives were satisfied with staff, including the responsiveness of staff to consumer’s care and service needs.
* One representative was not satisfied with the availability of staff to assist consumers at meal times. Management provided additional information on the assistance provided by staff to consumers during meal times.
* Clinical and care staff interviewed said they do not always have sufficient time to complete their duties; however, staff said there was no impact on the care and services provided to consumers. Staff said having lifestyle staff located in the MSU has assisted with the focus on consumers with known behaviours or at risk of falls.
* The service has processes for managing staff shortfalls. The Site manager said when shortfalls occur, the shifts are filled with either casual or agency staff. Staff interviewed said vacant shifts are replaced and described the process for the re-allocation of staff and shifts.

For the reasons detailed above, I find the approved provider, in relation to Eldercare The Lodge, does comply with Requirement (3)(a) of Standard 7.

# STANDARD 8 COMPLIANTOrganisational 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 Quality Standard is assessed as Compliant as one of the five specific Requirements have been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(d) in this Standard. This Requirement was found Non-compliant following an Assessment Contact conducted on 5 December 2019.

The Assessment Team recommended Requirement (3)(d) in Standard 8 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service is Compliant with Requirement (3)(d).

At an Assessment Contact – Site 5 December 2019, in relation to Standard 8, Requirement (3)(d), the Decision Maker found the service was unable to demonstrate that there were effective risk management systems and practices, including, but not limited to, managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and supporting consumers to live the best life they can. The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) Compliant

*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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the last Assessment Contact – Site, including

* The monitoring of staff compliance with processes relating to falls management, medication management and clinical incidents is undertaken daily by clinical leaders. Monitoring includes a review of progress notes, incident reports and clinical key performance indicators. Any gaps identified through this process is addressed.
* The service has implemented a monthly clinical data challenge to staff. Monthly clinical data includes a comparison of the previous month. The aim of the initiative is to increase staff awareness of clinical issues and to demonstrate where strategies have worked. Staff provided positive feedback regarding the initiative.
* Documentation viewed by the Assessment Team showed that between March and April 2020, there had been a reduction in behaviour incidents, medication incidents and the number of consumers with a weight loss greater than two kilograms. In addition, staff responses to call bells over 10 minutes had improved.
* The service has reviewed their diabetes management processes. A new diabetes management procedure and plan has been developed in consultation with Diabetes SA. The procedure incorporates a diabetes management plan, hypoglycaemia management protocols, control testing of glucometers and blood glucose monitoring. Staff said the new protocol is concise, easy to follow and promotes best practice. All consumers with diabetes have been reviewed under the new procedure.
* To improve the management and follow-up of consumers who have sustained a non-witnessed fall, the service has implemented a Falls checklist. The checklist prompts staff to review consumers post fall, including referral to allied health, a review of equipment and the commencement of neurological observations. A review of the completed checklists by the Assessment Team confirmed staff are following up on consumers post fall.
* In addition, a new Falls prevention strategies review process has been implemented for consumers who have had three or more falls in a month.
* The organisation’s Medication management policy has been updated. The new policy incorporates all aspects of medication management and replaces the organisation’s previous Medication administration policy. Staff said the information is easy to access with all information combined into one document.

The approved provider’s response demonstrated they agreed with the Assessment Team’s findings.

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

* The organisation has a documented risk management framework, including policies and procedures relating to the management of high impact or high prevalence risks associated with the care of the consumer, the abuse and neglect of consumers is identified and responded to, and how consumers are supported to live the best life they can.
* Staff interviewed were aware of the policies and processes and provided examples relevant to their work. Staff described the clinical incident reporting processes in line with their role, and provided examples of how they support consumers to live the best life they can.
* Consumers with high prevalence and high impact risks are identified through initial and ongoing assessment processes, including risk assessments. The organisation monitors the effectiveness of risk mitigation strategies through weekly Multi Disciplinary meetings.
* Clinical incident data is reported at a corporate level through reports to the Risk and audit sub-committee. Oversight and analysis of clinical incident data is undertaken monthly by the General manager of residential care and the Operational services executive. The organisation’s Clinical governance group also reviews information and results.
* There are processes for identification and management of abuse and neglect of consumers. Staff are educated on their reporting responsibilities at induction and through the organisation’s mandatory training program.
* To support the consumer to live their best life, consumer choices are supported through a risk-based process which include the completion of a risk activity assessment in consultation with the consumer and/or their representative.

For the reasons detailed above, I find the approved provider, in relation to Eldercare The Lodge, does comply with Requirement (3)(d) of 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.