Eyre Peninsula Old Folks Home

Performance Report

26 Flinders Highway   
PORT LINCOLN SA 5606  
Phone number: 08 8682 1868

**Commission ID:** 6046

**Provider name:** Eyre Peninsula Old Folks Home Inc

**Assessment Contact - Site date:** 11 August 2020 to 12 August 2020

**Date of Performance Report:** 12 November 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

|  |  |
| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(b) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-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, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 9 September 2020
* the Assessment Team’s report for the Assessment Contact – Desk conducted 7 May 2020.

# STANDARD 2 COMPLIANT 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 Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to all Requirements in this Standard. These Requirements were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit and have recommended Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e) as met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s reports and the approved provider’s response to come to a view of compliance with Standard 2 Requirements and find the service Compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

At the Review Audit, the Assessment Team found clinical assessments were not conducted for consumers during the respite period, initial assessments contained limited information about consumers’ assessed needs and appropriate assessments were not undertaken for consumers where there were indicators for an assessment to ensure delivery of safe and effective care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Updated the Assessment and Reassessment policy and procedure to reflect the need for all consumers, including those on respite, to have a formal support plan documented within the first week of entry and for reassessment to occur at six months or when there is a change in health status.
* The Admission pack has been expanded to include:
* General risk assessment
* Pain assessment, including tools for consumers’ with cognitive impairment
* Oral health
* Mini mental
* Continence profile
* Mini nutritional assessment
* Falls risk assessment
* Lifestyle and social history assessment
* Bowel management, incorporating non-pharmalogical interventions into the management plan
* Occupational therapy assessment, including dexterity
* Revised and updated the Assessment and care plan template to capture consumers’ goals, needs and preferences. The template is used for both respite and permanent consumers.
* At the time of the Assessment Contact, 38 of 59 consumers had the new template in place.
* Amended assessment documentation to reflect best practice tools. Tools include falls, delirium, malnutrition, pressure injuries and skin tears.
* Flowchart for assessment and support planning process developed. The document will be revised and published after the service has gone ‘live’ with the electronic database.
* Clinical nurse manager role introduced to monitor staff compliance with assessment processes. Allocated two nursing staff as ‘Admissions nurses’ to manage assessment and care planning processes and involve consumers and representatives in consultations.
* Arrangements have been made to ensure all consumers (respite and permanent) have functional assessments, including dexterity, by the Occupational therapist on entry and when health needs change.
* Updated the annual auditing schedule; this includes a care planning and assessment audit which assesses documentation, staff knowledge and consumer/representative satisfaction with the process.
* Updated the Unplanned weight loss policy to incorporate the need for a mini-nutritional and malnutrition assessment on entry.
* Oxygen therapy monitoring chart developed for consumers requiring regular or as needed oxygen.
* Pain management policy updated to reflect use of validated pain assessments for consumers with cognitive impairment and communication difficulties.
* Choking and swallowing difficulty procedure reviewed, and the Speech pathologist assessment tool updated to incorporate dietary requirements.
* ‘Best practice food and nutrition manual for aged care’ disseminated to kitchen, clinical and care staff and toolbox sessions held relating to thickened fluids.
* Risk assessment policy and procedure updated to include absconding risk.
* Staff training relating to Wound care and Defensible documentation conducted and training relating to the use of pain assessments, weight loss management, FRAT assessment and continence management scheduled.
* Purchased an electronic care system to streamline and simplify assessment and care planning processes. This is due to go live at the end of September/early October 2020.

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

All consumers and representatives are satisfied with care planning and assessment processes and confirmed individual risks had been identified and used to inform care and services.

Staff described assessment and planning processes in line with the service’s processes. All staff cited care plans as a primary source of knowledge regarding the delivery of care and services for each consumer and confirmed care plans contained sufficient information to guide practice.

Eleven consumer files viewed by the Assessment Team included completed and up to date assessments and care plans for both respite and permanent consumers. Care plans were individualised and included strategies relating to identified risks. Allied health assessments were incorporated into each consumer’s care plan assisting staff to provide care and services in line with consumers’ assessed needs and preferences.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(a) in Standard 2.

### 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.*

At the Review Audit, the Assessment Team found respite consumers’ complex needs were not consistently identified or assessed and clinical assessments to identify potential impact to nutritional status had not been initiated for 12 consumers identified as having unintentional weight loss.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Updated the Assessment and reassessment policy/procedure to reflect the need for all permanent and respite consumers to have a formal support plan documented within the first week of entry. This includes an assessment of pain and comfort care needs for palliative consumers.
* Goals from ‘My Aged Care’ are used to initiate discussions with consumers and representatives on entry.
* Added a Mini-nutritional assessment to the admission pack for all consumers.
* Reviewed the Unintentional weight loss policy, in addition to a referral flowchart to guide staff practice.
* All consumers have their weight measured monthly, which is evaluated and monitored. Changes in weight loss are identified and actions implemented, such as weekly or fortnightly weights; these are included in quarterly clinical indicator reporting.
* Staff training on weight management is being planned.
* Staff training on new assessment tools, forms, referrals to Dietitian and Speech pathologist.

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

Consumers and representatives confirmed consumer needs, goals and preferences are identified and care and services are tailored accordingly. One representative confirmed the service had identified and were respectful of a consumer’s mobility and skin integrity requirements and this was reflected in the care plan. Additionally, representatives confirmed staff had discussed consumers’ advance care and end of life planning with them on entry.

Staff were knowledgeable about consumers sampled describing personal and clinical care provided in line with their needs, goals and preferences. Staff demonstrated an awareness of consumers receiving palliative care and where they would acquire information relating to consumers’ needs, goals and preferences.

Permanent and respite consumer files included an initial Mini-nutritional assessment highlighting a malnutrition score, weight and Body Mass Index (BMI) score. Where unintentional weight loss or gain had been identified, weekly or fortnightly weights had commenced, referral and review by Medical officers initiated and strategies implemented.

Advance care plans and terminal wishes documentation were noted in most consumer files, however, dates of completion or review had not been consistently updated on terminal wishes forms. Resuscitation status of consumers is noted by coloured dots on consumer files of which all staff were familiar. Recently completed end of life plans were noted in palliative care consumer files; these are reviewed monthly or as needs change.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(b) in Standard 2.

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

At the Review Audit, the Assessment Team found the service did not demonstrate consumer and/or representative involvement in assessment, planning and review of care and services and assessment and planning did not include an integrated approach with providers outside the service who are involved in provision of consumer care.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Assessment and care planning template revised to promote and include evidence of collaboration and approval by consumers and/or representatives prior to implementation.
* Consumers and/or representatives are invited to review the latest assessment and care plan proposal. Changes are made in line with the consumer/representatives’ wishes, the document printed, signed by the consumer and/or representative and nurse and a copy provided.
* This process was confirmed by staff and representatives and evident in consumer files.
* Audit to assess whether consumers and/or representatives were satisfied with the care planning and assessment process and were involved in discussions has been conducted. The audit identified four of five consumers and/or representatives sampled were consulted in care planning.
* The service reported there has been positive feedback about the new care planning process from consumers and representatives
* Reviewed the Occupational therapist’s schedule to twice weekly visits enabling completion of functional assessments at scheduled six-monthly reviews and following incidents, such as falls.
* Trained two nurses for the role of ‘Continence specialist’. Responsibilities include managing and reviewing continence assessments and reassessments.
* The service plans to schedule additional staff training on continence products and care.

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

All but one care plan viewed was signed and authorised by the consumer and/or representative. Some care plans were noted to have been signed after implementation between March and August 2020, however, entries in progress notes detailed families had been informed of changes but had been unable to sign due to COVID-19 visitor restrictions.

All consumer files included a functional assessment completed by the Occupational therapist. Where changes to consumers’ care and service needs had been identified, referrals had been initiated, Medical officer or allied health reviews conducted, and new strategies incorporated into care plans. Consumer files indicated representatives had been informed of updates to care plans.

Consumers and representatives interviewed confirmed involvement in care plan reviews and described the process as a positive experience. Representatives felt satisfied they were informed of any changes to the care plan and confirmed the service involved others, such as Medical officers and allied health specialists when needed.

Staff described how they involve consumers, representatives and others in assessment and care planning and were aware of the communication channels and referral pathways for ensuring involvement and collaboration.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(c) in Standard 2.

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The Assessment Team assessed Requirement 3(d) in relation to Standard 2. At the Review Audit, the Assessment Team found the service did not demonstrate effective communication with consumers and/or representatives following assessment and planning or that they consistently updated consumer care plans following changes to care.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Revised the Assessment and care planning template to incorporate consumers and representatives into the assessment and care planning process.
* Staff are required to collaborate and communicate with consumers and representatives on the outcomes of assessment and planning and provide them with a copy of the authorised care plan.
* Staff reminded of the need to communicate with consumers and representatives at a staff meeting in held in April 2020.
* Informed all consumers and their representatives of their right to access information relating to consumers care and services through the newsletter.
* Representatives are currently receiving email updates about care and services from the administration team and a Facebook page has been set up.

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

Each consumer has a printed Support plan which includes a clear outline of the needs, goals and preferences of consumers.

Consumers and representatives said they had been informed of the outcome of assessments and involved in care planning. Additionally, representatives confirmed they can access a copy of the care plan if they wish and would have no hesitation in requesting further information if required. Staff confirmed consumers can request to see their care plan at any time.

Staff described how they communicate care plan changes to consumers and representatives, including at scheduled six-month reviews and when/if needs change. The Assessment Team observed care plans to be readily available to staff delivering care.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(d) in Standard 2.

### Requirement 2(3)(e) Compliant

*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.*

At the Review Audit, the Assessment Team found the service did not demonstrate effective review of services when changes for consumers in relation to nutrition and hydration, behaviour management and/or pain management are identified. Additionally, care plan strategies were not reviewed to maximise the safety and effectiveness of care and services in line with consumers’ gaols and/or preferences.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Review schedule updated to detail when initial care assessments and care plan reviews are due. This is process is monitored monthly
* Altered the assessment and care planning structure by designating the responsibility and oversight of care plans, assessments and referrals to two designated Admissions nurses.
* A Nurse communication book captures when referrals and reassessments are due and require follow up. This is further noted in daily handover templates, which are reviewed weekly by a senior clinical manager.
* Purchased an electronic care system to improve information systems and more effectively monitor and review when assessments, care plans and reviews are due.
* Falls management protocol reviewed and updated and flow chart to include the need to assess pain and have an Occupational therapist review post fall.
* Staff training relating to psychotropic medication and behaviour management is scheduled.
* Monthly monitoring of weight loss ensuring referrals are initiated when appropriate. The Unplanned weight loss policy has been reviewed.
* Four care files viewed for consumers identified in previous reports demonstrated pain and continence needs had been identified and re-assessed, including when consumer needs had change.

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

Care plans viewed had been reviewed and updated within a six-month period in line with the service’s policy and/or when consumer needs, goals or preferences had changed. Consumers’ needs and goals had been reviewed regularly, and care and services altered to reflect current care needs and preferences.

Where consumers had experienced unintentional weight loss this had been identified, more frequent weight monitoring implemented, consultation with the Medical officer had occurred and strategies reviewed and documented in the care plan.

Representatives confirmed consumer care and service plans are regularly reviewed, including when circumstances change, or incidents occur. One representative confirmed change to a consumer’s needs had been discussed with them and the consumer, and the care plan revised to reflect current needs and preferences.

Staff described requirements for assessment and care plan reviews in line with the service’s process and provided examples of when consumer care plans had been reviewed and updated following incidents, such as falls and pain.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(e) in Standard 2.

# STANDARD 3 NON-COMPLIANT 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 Quality Standard is assessed as Non-compliant as three of seven specific Requirements have been assessed as Non-compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to all seven Requirements in this Standard. These Requirements were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit and have recommended Requirements (3)(c), (3)(e) and (3(f) as met. The Assessment Team were not satisfied actions implemented in relation to Requirements (3)(a), (3)(b), (3)(d) and (3)(g) have sufficiently addressed the deficiencies identified at the Review audit and have recommend these Requirements not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s reports and the approved provider’s response to come to a view of compliance with Standard 3 Requirements and find the service Compliant with Requirements (3)(c), (3)(d), (3)(e) and (3(f) and Non-compliant with Requirements (3)(a), (3)(b) and (3)(g). I have provided reasons for my decision in the specific Requirements below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found some consumers were not receiving personal or clinical care that was best practice, tailored to their needs or which optimised their health and well-being. This was evidenced by the following:

* Staff did not manage a consumer fall in July 2020 in line with the service’s post fall’s management processes. The consumer fell back heavily onto their back whilst mobilising with staff. Another staff member retrieved a lifter strap, placed it on the floor and proceeded to attempt to roll the consumer onto to it. The consumer became very distressed and staff stopped the activity and sought further assistance from a supervisor. The consumer was then transferred to hospital and was identified with a fractured leg.
* The incident was investigated and found staff had provided personal care to the consumer in an unsafe manner and had not followed the service’s post fall's assessment process before attempting to move the consumer from the floor.
* The representative stated when the consumer arrived at the hospital, they observed them wearing an incontinence aid which smelt bad. The representative stated they had observed issues that suggested assistance with the consumer’s personal hygiene was not consistently well managed.
* Management advised the consumer had a continence management plan and personalised toileting schedule, but they sometimes resist staff interventions toilets independently.
* Progress notes dated 22 to 29 May 2020 viewed by the Assessment Team record some non-compliance with personal care but not specifically in relation to toileting.
* Three insulin dependent diabetic consumers did not have a Diabetic care plan or directive outlining blood glucose level parameters, frequency of blood glucose level monitoring or actions to take when blood glucose levels were high or low.
* One consumer’s blood glucose level was recorded at 22.6mmol/L on 10 August at 5.00pm. The blood glucose level was not repeated until 11 August 2020 at 7.40am.
* The hyperglycaemia policy indicates staff are to continue to monitor blood glucose levels as directed by the Registered nurse, however, no timeframe is given.
* The Hypoglycaemia policy outlines symptoms of the condition but does not detail management or actions to be taken.
* One consumer with communication difficulties requires staff to take extra time to communicate with them. The consumer stated staff are often rushed and do not take the time to listen, ignore them and talk over the top of them to each other as if they are not there. The consumer also said some staff do not make any effort to communicate with them which makes it difficult to express their wishes for how they would like their care delivered. The consumer said they sometimes need help with things but because staff do not communicate with them, they cannot tell them what they want, and they find this frustrating.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Sourced and developed a Diabetes management plan tool in line with best practice.
* Updated hyperglycaemia and hypoglycaemia policies and protocols.
* Education materials relating to communicating with people with difficulties has been distributed to staff.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Accessed and implemented best practice tools in relation to continence care, pain management and social profiling of consumers to better understand their needs, goals and preferences.
* Staff education in relation to wound and continence care has been interrupted by COVID-19 restrictions. In the meantime, clinical management is working informally to assist staff understand the new processes and intends to introduce toolbox sessions later.
* Staff training in relation to hand hygiene and manual handling.
* Introduction of an electronic care system is anticipated at the end of September 2020 which will provide an additional suite of procedures and assessment tools to guide staff.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact clinical and personal care provided to consumers, specifically in relation to diabetes and falls management was not in line with best practice. Additionally, one consumer provided feedback to the Assessment Team relating to communication processes with staff which did not demonstrate their health and well-being was being optimised.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(a) in Standard 3.

### Requirement 3(3)(b) Non-compliant

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

The Assessment Team found high impact, high prevalence risks in relation to falls management and behaviour management are not always effectively managed. This was evidenced by the following:

Falls management

* One representative stated they were concerned about how staff managed a consumer immediately following a fall.
* Management stated care staff had not followed the service’s post falls management process, attempting to move the consumer before seeking further assistance and assessment from a supervisor. A care worker retrieved a sling strap and placed it on the floor next to consumer and attempted to roll them onto it without an assessment causing the consumer to call out in pain.
* The care worker sought further assessment from a supervisor at this point. The consumer was transferred to hospital and treated for a fractured leg.

In relation to behaviour management

* Behaviour support plans viewed for two consumers do not adequately identify consumers’ behaviours, associated risks or provide guidance for staff in relation to deflection or minimisation of the behaviours.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Supporting documentation provided included actions taken since the Review Audit, including:

* Weight management education conducted March 2020 attended by 16 clinical staff.
* Dementia – solving difficult behaviours training conducted in March 2020 attended by 52 care staff.
* Wound care and dressing techniques training conducted in February 2020 attended by 14 clinical staff.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Implementation of an electronic care system to assist with development of support plans and monitoring of consumers’ risks.
* Risk assessment tools, including a Delirium screen have been implemented.
* Relevant risk assessments are included in assessment packs for new consumers and are utilised for the reassessment of existing consumers.
* Updated medication documentation processes to include a separate sheet for staff to record variations in anticoagulant therapy.
* Developed an Oxygen therapy treatment chart to monitor administration of ‘as required’ oxygen.
* Education relating to risks of physical restraint has been provided to relevant consumers and representatives.
* Commenced Clinical meetings to discuss clinical problems and to provide direction and support for staff.
* Commenced trending of clinical incidents. Clinical summaries viewed by the Assessment Team show trending of clinical data has occurred since March 2020.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact high impact or high prevalence risks, specifically in relation to falls and behaviour management were not being effectively managed for each consumer.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(b) in Standard 3.

### 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.*

At the Review Audit, the Assessment Team found the organisation did not demonstrate care needs and goals of consumers nearing the end of life were recognised and addressed. Two deceased consumers did not have their pain needs recognised and comfort measures were not adequately managed.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Reviewed and updated the Palliative and End of life protocol to include pain management and social support. This includes a palliative checklist and observational pain assessment tool.
* Pain assessment inclusive of an observational tool to be used to capture non-verbal pain cues and to prevent signs of pain being mistaken for behaviours
* All respite consumers to have routine and as needed pain assessments.
* Updated the Assessment and care planning policy to reflect the need for respite consumers to have a full risk assessment and support plan implemented within the first week of entry.
* Reviewed Social well-being care plans to ensure all reflected changes in care needs, including social and cultural requirements.
* Training on palliative and end of life care, as requested by staff is likely to be rolled out in September 2020.

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

Care files for palliative consumers included an alert highlighting they were receiving palliative care and a Palliative support plan and End of life pathway. Support plans include interventions for each assessment, such as nutrition and hydration, skin integrity, oral care, continence, pain and mobility. A full support plan includes a detailed assessment and each consumer’s individualised needs, goals and preferences. All files demonstrated regular monitoring of pain and commencement of pain assessments when consumers expressed pain or indications of pain were observed by staff.

Care and clinical staff were knowledgeable about the consumers receiving palliative care and described how the delivery of care and services had changed in response to consumers’ changing needs. Staff also provided examples of how they ensure care is provided in a way which promotes privacy, dignity and respect

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(c) in Standard 3.

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

*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.*

The Assessment Team found staff training in relation to clinical deterioration of consumers and distribution of best practice guidelines for staff have had not occurred. This was evidenced by the following:

* Training and distribution of best practice guidelines relating to clinical deterioration of elderly patients is due to be undertaken on 30 August 2020.
* Infection surveillance charts to track infections/suspected infections has been implemented, however, consumer infections and antibiotic therapy is not being adequately monitored through the process.
* Introduction of an electronic care system in September 2020 will provide a new model of care, additional tools and reporting processes to assist identify and investigate consumer health changes.

The approved provider’s response indicated they did not dispute the Assessment Team’s findings. However, I note the Assessment Team’s report indicates:

* Two consumers stated they are confident staff would identify a deterioration in their health status and would respond appropriately.
* Two representatives said they are informed when their relative or friend has a change in their health status, and they have been satisfied with the service’s response.
* One consumer file sampled demonstrated the consumer had been promptly transferred to hospital on two occasions following a change in condition.
* Progress notes for one consumer sampled indicated an allied health referral had been initiated in response to staff observing the consumer spending significant time in bed with reduced mood and motivation. The support plan was updated to guide staff in relation to supporting the consumer.
* One care staff described how they had reported a change in a consumer’s condition to the supervisor.
* Two care staff stated they are informed of changes to consumers’ care and service needs through the handover process.
* Documentation viewed by the Assessment team demonstrated consumers are frequently referred to Medical officers for review.
* Information relating to changes to consumers’ health status and actions is documented on the handover sheet.

At the Review Audit, the Assessment Team found the service did not demonstrate deterioration or change of a consumer’s condition is recognised and responded to in a timely manner. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Requests for Medical officer reviews in response to changes in consumers health are documented in Medical officer logbooks located in each nurses’. The process has been refined to include collating names of consumers and their well-being issues for each Medical officer. Telephone contact is conducted weekly to ensure each Medical officer is informed of the number of consumers requiring review and the type and urgency of the issues. The process has ensured consumers are being reviewed by their Medical officers more regularly and no-one is being missed.

Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. I acknowledge at the time of the Assessment Contact not all actions on the service’s Plan for continuous improvement to address the deficiencies identified at the Review Audit had been implemented. Staff had not been provided training in relation to clinical deterioration of consumers and best practice guidelines had not been distributed to staff.

However, the Assessment Team’s report provided evidence demonstrating deterioration in a consumer’s condition is recognised and responded to in a timely manner. Consumers stated they were confident staff would identify and respond to deterioration in their health and representatives stated they had been satisfied with the way the service had managed changes to consumers’ changing health needs. There are processes to initiate referrals to Medical officers and/or allied health specialists and communication processes are in place to alert staff of any changes to consumers’ care and service requirements.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(d) in Standard 3.

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

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

At the Review Audit, the Assessment Team found the organisation did not demonstrate information in relation to consumers’ condition, needs and preferences was documented and communicated within the organisation and with others where responsibility for care is share.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Staff training provided in relation to Dementia and the new social profiling tool and person-centred care.
* Social profiles have been completed for all consumers.
* Recruited a male staff member to ensure consumers who express staff gender preferences are able to be accommodated.
* All consumers have information in care plans detailing their condition, needs and preferences.

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

Consumers and representatives confirmed they understood the circumstances in which information about consumers would need to be shared with others. Additionally, consumers and representatives stated staff who care for consumers know them, provide care in line with their preferences and understand them as individuals.

Consumer files included completed forms relating to emotional, spiritual, cultural and psychosocial well-being and a Social and human needs support plan identifies lifestyle goals. All consumer files viewed included regular progress note entries relating to consumers’ well-being.

Care staff described needs, goals and preferences for individual consumers in line with documented support plans. Staff stated they receive information relating to consumers, including changes to their care and service needs through the staff handover processes.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(e) in Standard 3.

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

At the Review Audit, the Assessment Team found the organisation did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* A Nurse communication book identifies when referrals are due and consumers who require follow-up.
* A Medical officers’ logbook is located in each nurses’ station for staff to enter requests for Medical officers when a consumer is identified as requiring referral. There are processes to ensure each Medical officer is notified of required referrals/review. This process has ensured consumers are reviewed, referred to specialists and/or transferred to hospital as necessary.
* Daily handover templates are used to record consumers who require referrals and to ensure this information is communicated to staff on the following shifts.
* Functional assessments have been completed for all consumers by the Occupational therapist. The Occupational therapist is also reviewing consumers post falls.
* The Occupational therapist is now on site twice a week to complete assessments/re-assessments as scheduled.
* Updated policy and procedure relating to change in consumers’ circumstances triggering referrals.
* The Incident template includes a section prompting staff to provide a description of the incident, what happened and how it occurred.

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

Consumers and representatives confirmed they were confident staff would take appropriate action a consumer required referral to other health specialists.

Consumer files viewed demonstrated, following falls, consumers are reviewed by the Occupational therapist and care plans updated to reflect appropriate management strategies. Consumer files also demonstrated referrals are initiated and care plans updated in response to identification of weight loss and dietary issues. Progress notes for one consumer indicated the consumer was promptly transferred to hospital in relation to changes in their health and well-being.

Clinical staff described referral processes and provided examples of consumers who had recently been referred to health care specialists and transferred to hospital. Staff discussed the Daily handover template, describing how required actions for consumers identified as requiring referral are recorded ensuring follow up.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(f) in Standard 3.

### Requirement 3(3)(g) Non-compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The Assessment Team found updated policies do not provide practical advice for staff in relation to minimising antibiotic use or reference COVID-19. Additionally, an infection control template does not adequately monitor or include outcomes to indicate follow-up has occurred for consumers following completion of antibiotics. This was evidenced by the following:

* The Checklist for healthcare associated infections practice and the Infection prevention and control policy do not include or reference COVID-19.
* The Infection control policy:
* states personal protective equipment is always available, and staff have access to ‘gloves, plastic aprons and eyewear’. However, the policy does not mention face masks
* includes an antimicrobial stewardship statement, however, there is no guidance or reference to direct staff to practical information about how to minimise the use of antibiotics for consumers.
* Infection surveillance charts to track infections/suspected infections has been implemented, however, consumer infections and antibiotic therapy is not being adequately monitored through the process.
* The Assessment Team noted the outcome column is mostly blank indicating staff are not adequately monitoring consumers’ infection status or reviewing the effectiveness of the therapy

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Staff have been provided links to personal protective equipment training.
* COVID-19 Marshal training completed by four staff in August 2020.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Updated the Infection prevention and control policy to include guidance for staff, inclusion of antimicrobial stewardship and minimising use of antibiotic.
* Development of an infection control report to include investigation, evaluation, and reduction in infections and antibiotic use is pending. Opportunities to develop infection control reports are expected when the electronic care system is introduced.
* An Infection control audit completed March 2020 identifying staff needing/wanting more training has not been fully responded to. Staff have not yet any had practical training in the use of PPE.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact policies available to staff do not provide sufficient information in relation to minimising antibiotic use or reference COVID-19. Additionally, the service’s processes for monitoring consumer infections does sufficiently provide information to indicate follow-up has occurred for consumers following completion of antibiotics.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(g) in Standard 3.

# STANDARD 4 NON-COMPLIANT Services and support for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team assessed Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in relation to Standard 4. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit and have recommended Requirements (3)(a), (3)(c) and (3)(d) as met. The Assessment Team were not satisfied actions implemented in relation to Requirement (3)(b) have sufficiently addressed the deficiencies identified at the Review audit and have recommend this Requirement not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s reports and the approved provider’s response to come to a view of compliance with Standard 4 Requirements and find the service Compliant with Requirements (3)(a), (3)(c) and (3)(d) and Non-compliant with Requirement (3)(b). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

At the Review Audit, the Assessment Team found for three consumers the organisation did not demonstrate supports for daily living met the needs, goals and preferences or optimised their independence, health, well-being or quality of life.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Development of a social profile which identifies each consumer’s specific social, cultural and religious needs.
* Involvement of consumers and representatives in care plan reviews, ensuring needs, goals and preferences are effectively captured and reflected.
* Development and implementation of new activities, including a Men-only country western movie night, the acquisition of a snooker table and purchase of a new bus.

In relation to Standard 4 Requirement (3)(a), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

Consumers and representatives confirmed consumer needs, goals and preferences have been identified and they are supported to engage in hobbies and activities of interest to them. One representative described how staff had sought an understanding of the consumer’s life history and on identifying their interest in children, had acquired a doll for them to care for, greatly improving the consumer’s agitation and behaviours and optimising their emotional well-being.

Consumer files included a Religious, social and cultural care plan identifying specific interests and preferences, such as religious affiliations and festivals they wish to celebrate. Each consumer has an individual monthly activity plan outlining individualised activities. Staff stated a blank schedule is commenced each month to avoid care becoming standardised and promote flexibility to consumers’ changing needs, goals and preferences.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(a) in Standard 4.

### Requirement 4(3)(b) Non-compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team found the organisation did not demonstrate that services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being have not been fully implemented*.* This was evidenced by the following:

* Cultural awareness training has been attended by only one staff member, the Occupational therapist. Cultural training for the remaining staff members is pending.
* An Emotional, spiritual and psychological well-being assessment has been developed. However, while the consumers have been assessed, the information has not yet been analysed in sufficient detail to develop an Activities program inclusive of all individual consumers’ requirements.
* Staff confirmed the current Activities program does not really cater for men and they have been investigating opportunities to engage men in more meaningful activities.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Developed a care plan template to capture consumer preferences relating to cultural care and meaningful activities.
* Introduction of a social profile tool
* Sourced a multicultural calendar to prompt special days.
* Sourced Multicultural Aged Care guide to best practice.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s reports and the approved provider’s response, I find at the time of the Assessment Contact while assessments have been completed to identify each consumer’s emotional, spiritual and psychological well-being needs and preferences, this information has not been analysed to assist the service to implement an activities program inclusive of all consumers’ requirements.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(b) in Standard 4.

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

At the Review Audit, the Assessment Team found the organisation did not demonstrate that services and supports assisted each consumer to participate in their community within and outside of the organisation’s service environment or do things of interest to them.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Sourced a social profile tool. Comprehensive assessment of each consumer’s social and life history has commenced, and information will be used to develop meaningful activities and guide staff practice.
* Purchased a larger bus to enable more consumers to access the community and region.

In relation to Standard 4 Requirement (3)(c), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

Consumers confirmed they are supported to have and maintain social and personal relationships and described frequent occasions when family and friends visited or escorted them away from the facility. Consumers and representatives stated during lockdown due to COVID-19, the service facilitated conversations and visits with friends and family over the telephone, or through the screen door at the service.

Consumer support plans include an individualised template relating to social and human needs, as well as family, friends and community support plan. However, not all consumer files included a completed life history assessment. Staff stated this is in progress and are working with consumer representatives to gather a comprehensive history.

Staff provided examples of how consumers are supported to participate in the community and maintain relationships with people important to them. Staff were familiar with individual consumer’s interests and could identify social and personal relationships that were important to them.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(c) in Standard 4.

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

At the Review Audit, the Assessment Team found the organisation were unable to demonstrate consumers’ condition, needs and preferences were effectively communicated within the organisation and with others where responsibility for care was shared.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Risk lists for consumers who go on bus trips are in place and include consumers’ dietary, mobility and cognitive needs.
* Information relating to consumers’ needs, goals and preferences, including emotional, spiritual and well-being needs, and family information is documented in support plans which are accessible to all staff.

In relation to Standard 4 Requirement (3)(d), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

All sampled support plans viewed included each consumer’s needs, goals and preferences. Support plans are located in the nurses’ stations and the Assessment Team observed staff to access them frequently.

Consumers and representatives confirmed consumers are provided care in line with their needs, goals and preferences and staff know them as individuals. Additionally, consumers and representatives confirmed staff have correct and current information about consumers and their care and services are provided in a consistent manner.

A Lifestyle staff member stated they only take small groups on outings and always take the risk list with them. The staff member stated they have access to support plans and can review information at any time. Additionally, staff described needs, goals and preferences for individual consumers in line with documented support plans.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(d) in Standard 4.

# STANDARD 5 Organisation’s service environment

### Consumer outcome:

1. I feel I belong, and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team assessed Requirement (3)(b) in relation to Standard 5. All other Requirements in this Standard were not assessed.

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 Review Audit conducted 30 October 2019 to 1 November 2019.

The Assessment Team assessed Requirement 3(b) in relation to Standard 5. At the Review Audit, the Assessment Team found the service was unable to demonstrate the service environment was secure to ensure the safety of consumers with cognitive impairments or consumers were able to move freely both indoors and outdoors. The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Review 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 reports to come to a view of compliance with Standard 5 Requirement (3)(b) and find the service Compliant with Requirement (3)(b). I have provided reasons for my decision in the specific Requirement.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* All but two external doors have been fitted with electronic keypads for access and egress. Keypads will be fitted to the remaining doors.
* Thirty-two closed circuit television cameras have been installed around the facility providing real time vision of all exits and traffic areas within the facility. Management and staff are able to monitor the cameras from the Chief executive officer’s office and nurses’ stations. Footage is recorded automatically and can be readily viewed if required.
* Inverted glass doors are fire doors and cannot be changed. Staff are available to assist consumers who are unable to open doors themselves.
* Staff practice audits have been undertaken to address staff smoking within five meters of the building and in view of consumers. Staff have been provided the service’s smoking policy, and a dedicated smoking area has been developed.
* Staff can also be monitored via CCTV leaving the building when on breaks to ensure smoking only occurs in the designated area.
* A tracking pendant was utilised for one respite consumer who was risk assessed as being a high risk of wandering.
* An audit of staff knowledge with regard to missing consumers has been conducted and training implemented.

In relation to Standard 5 Requirement (3)(b), documentation viewed, observations, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

The Assessment Team observed the environment to be clean, with no malodour. Corridors were clear, and independently mobile consumers and those in wheelchairs were observed mobilising with no impediment. Outdoor areas were well maintained with paths clear and grass mown. Maintenance logs viewed demonstrated responsive maintenance is undertaken in a timely manner and ongoing maintenance occurs as required.

The three secured areas of the service require keypad access with other areas able to be secured as necessary. Consumers who are deemed able to use the keypads are provided codes. For monitoring purposes during COVID-19, access into and out of the service is limited to the front reception door. Staff assist consumers who are unable to utilise the keypads.

Consumers said they can go outside if they want to. One consumer said they like to sit outside in their wheelchair and enjoy the sunshine whenever they can, and staff assist them to do so. Three consumers said they feel safe at the service as the buildings are secure and staff are always available to look after them.

Staff described processes for reporting maintenance issues in line with the service’s process. Care staff described how they report issues requiring urgent attention and how nursing staff would arrange for someone to attend to the issue. Staff and management described how consumers with limited ability are assisted to move about the facility using specialised equipment, such as four wheeled walkers and wheelchairs and stated staff are available to assist consumers where required.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(b) in Standard 5.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Assessment Team assessed Requirements (3)(a), (3)(c) and (3)(d) in relation to Standard 6. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019.

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Review Audit and have recommended these Requirements as met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s reports to come to a view of compliance with Standard 6 Requirements (3)(a), (3)(c) and (3)(d). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

At the Review Audit, the Assessment Team found whilst the organisation demonstrated that it provided avenues for consumers and representatives to provide feedback and make complaints, it could not demonstrate consumers and representatives were encouraged and supported to provide feedback and complaints.

### The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Consumers are reminded of feedback mechanisms and encouraged to make suggestions and complaints through the three monthly resident meetings.
* A consumer survey was conducted in February 2020 to give consumers opportunity to provide feedback.
* A Facebook page has been created to give consumers, their families and friends opportunity to provide feedback in an alternative manner.
* Complaints logs are located in care stations for staff to record verbal feedback received. Feedback recorded collated by a designated staff member who directs feedback to the appropriate area for action and ensures the Chief executive officer is aware of feedback received.
* Feedback is sought daily in relation to meal provision and is provided to the kitchen.
* A memorandum was sent out to staff reminding them of complaints processes and the need to capture verbal complaints to enable appropriate follow up to occur.
* Implemented a new Complaints policy which has been placed in care stations for all staff to read.

In relation to Standard 6 Requirement (3)(a), documentation viewed, observations, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

Consumers confirmed they are aware of and utilise feedback systems and staff assist and encourage them to provide feedback if they wish to do so. Consumers described ways by which they can provide feedback, including raising concerns at meetings, feedback forms, emails or by speaking to staff directly. Consumers described examples of complaints raised and stated concerns have usually been addressed appropriately and they felt comfortable speaking up.

Staff described actions they take when they receive a complaint from a consumer in line with the service’s processes. Staff described how they capture verbal complaints, encourage consumers to use feedback forms and notify nursing staff of complaints raised. Where serious concerns are raised, staff stated they would advise management directly.

‘Have your say’ forms are located in the service’s common areas and feedback boxes are available and posters and pamphlets relating to internal and external complaints processes and advocacy services are available.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(a) in Standard 6.

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

At the Review Audit, the Assessment Team found the organisation did not adequately demonstrate appropriate action was taken in response to complaints or that it understood and consistently applied an open disclosure approach to complaints.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Delegating a staff member to collect and collate all complaints received and to ensure follow up occurs in a timely manner.
* The assessment process is used to provide consumers and representatives an opportunity to raise concerns and receive follow up
* Developed an Open disclosure policy.
* Reminders to staff to ensure open disclosure occurs for all clinical and adverse events.
* All complaints received are reported to the Board on a monthly basis.
* The Vice Chair of the Board attends the service weekly and meets with the Chief executive officer to ensure the Board are kept advised of all complaints and issues of concern.
* A Board member attends each Resident meeting.

In relation to Standard 6 Requirement (3)(c), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

The service has implemented systems to enable appropriate action to be taken in response to complaints. Management and staff demonstrated they understand and consistently apply an open disclosure approach when things go wrong, and staff gave examples of when open disclosure has been used.

Consumers and/or their representatives stated the service addresses concerns raised regarding consumers’ care in a timely manner and apologises where appropriate. A representative described the service’s actions following a serious incident and said the service contacted them regarding the incident and had apologised for the actions that led to the incident occurring.

Staff demonstrated an awareness of the service’s complaints management processes and described actions taken to address issues raised. Clinical staff described principles of open disclosure and when it is appropriate for it to be used.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(c) in Standard 6.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

At the Review Audit, the Assessment Team found the organisation did not demonstrate feedback and complaints were reviewed and used to improve care and services.

The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Consumer feedback is collated and reviewed on a weekly basis.
* Implemented a continuous improvement plan to effectively capture opportunities for improvement identified through complaints.
* Opportunities for improvement identified through complaints are discussed with the Vice Chair of the Board on a weekly basis to ensure Board oversight and review occurs.

In relation to Standard 6 Requirement (3)(d), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

The service has implemented systems to ensure feedback and complaints are reviewed and opportunities for improvement identified and used to improve the quality of care and services provided.

Consumers expressed satisfaction with improvements implemented as a result of their concerns. One consumer described changes to the activities program to include a men’s movie night which they greatly enjoyed, and several consumers discussed changes to the provision of meals. Additionally, staff described examples of improvements implemented to improve the delivery of care and services to consumers.

The service’s complaints register viewed by the Assessment Team reflected issues identified and actions taken to address them. A Continuous improvement plan included improvements identified from complaints and suggestions received.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(d) in Standard 6.

# STANDARD 7 NON-COMPLIANT Human 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 Assessment Team assessed Requirements (3)(c), (3)(d) and (3)(e) in relation to Standard 7. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c), (3)(d) and (3)(e) in this Standard. Requirements (3)(c), (3)(d) were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019. Requirement (3)(e) was found Non-compliant following an Assessment Contact conducted 18 February 2020.

The Assessment Team have recommended Requirements (3)(c), (3)(d) not met and Requirement (3)(e) met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s reports and the approved provider’s response to come to a view of compliance with Standard 7 (3)(e) and find the service Non-compliant with Requirements (3)(c), (3)(d). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(c) Non-compliant

*The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team found the service did not demonstrate all staff are competent or have the necessary skills or knowledge to effectively perform their roles. This was evidenced by the following:

* Two care staff stated they had not received training in donning and doffing personal protective equipment.
* Clinical management said staff have not received training in the use of personal protective equipment, including masks and gowns as the service did not have sufficient supplies of gowns, masks or gloves for all staff to practice with.
* One care staff member demonstrated incorrect procedures for removal of a mask.
* One personal care worker said they did not feel confident they would be able to safely care for a consumer with COVID-19 or know whether the service had an outbreak management procedure. They said they had not received any training on this and supposed they would be guided by the nursing staff.
* One personal care worker said they were aware new policy and procedure manuals had recently been placed in the care stations but had not received training about them or read them.
* Management said scheduled training related to pain management was cancelled due to COVID-19 and has not yet been undertaken.
* Clinical management stated cultural awareness training has been attended by only one staff member and training for the remaining staff members is still pending.
* Training relating to clinical deterioration identified as required following the Review Audit conducted in November 2019 has not yet occurred.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report.

The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Care staff must have a minimum Certificate III qualification before being hired
* Creation of a training plan for future training which is targeted at identified Non-compliant Requirements.
* Initiated a Clinical nurse manager role in March 2020 to enable monitoring and oversight.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Assessment Contact the service did not demonstrate training, specifically in relation to key clinical areas has been provided to staff. Additionally, staff stated they had not received training in the correct use of personal protective equipment and were not all confident they would know what to do in the event of an outbreak.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(c) in Standard 7.

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found staff were not trained or equipped to deliver outcomes required by the Quality Standards. This was evidenced by the following:

* Training records indicate no staff have completed the organisation’s annual mandatory training modules since August 2019.
* A training schedule has been formulated based on gaps in staff knowledge identified at the Review Audit conducted 30 October to 1 November 2019. Management said training has been delayed due to COVID-19.
* Clinical and care staff said they have received very little training since March 2020 due to COVID-19.
* Two personal care workers said they have not received training in the use of personal protective equipment. This was confirmed by clinical management who said they have not undertaken training in the use of personal protective equipment with staff as the service does not have sufficient personal protective equipment for all staff to use it for training.
* The development of a competency sheet for tasks performed related to clinical and personal care has not yet been completed.
* Management stated specific training in relation to actions identified in the service’s Continuous improvement plan had not been completed. Clinical training has not been completed for relevant staff in relation to continence and wound management or deterioration or change in a consumer’s mental health, cognitive or physical function.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Assessment Contact the service did not demonstrate staff have been provided with sufficient, ongoing training to support them to deliver the outcomes required by the Quality Standards. The service’s mandatory program has not been maintained and training to address the deficits identified at the Review Audit have not been completed in line with the service’s Continuous improvement plan.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(d) in Standard 7.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

At the Assessment Contact, the Decision Maker found the service did not effectively or adequately manage the performance of a staff member whose practices were repeatedly causing harm to a consumer. The approved provider was aware the care staff member was under performing and had established a pattern of their care provision causing harm to the consumer, actions to address the consumer implemented were not adequate, effective or in accordance with the service’s performance management and development processes.

The Assessment Team’s provided evidence of actions taken to address deficiencies identified at the Assessment Contact conducted 18 February 2020, including:

* Evidence of performance management actions taken for three staff provided was in line with the organisation’s processes and included one relating to poor performance and two in response to incidents where consumers’ care was reported to be unsatisfactory.
* One staff member was terminated following a performance management process. Two staff received counselling, additional supervision requirements and warnings.
* Performance management documentation viewed reflected ongoing monitoring and review of staff practice following incidents and complaints.
* The organisation has a schedule of audits which include assessment of staff performance against clinical outcomes.
* A review of staff counselling performance development was undertaken in March 2020.
* A position of Clinical nurse manager has been created to monitor staff practice and clinical care.

In relation to Standard 7 Requirement (3)(e), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

The service demonstrated monitoring and review of the performance of each member of the workforce is undertaken.

Staff stated they participate in an annual performance review, have opportunity to discuss their skills and training needs and receive feedback on their performance. Feedback from consumers, representatives and others is used to monitor the performance of staff. There are processes to observe staff skills and performance and where poor performance is identified action is taken and support provided.

Senior clinical staff described performance management processes implemented for two care workers involved in an incident with a consumer. This included meeting with the Chief executive officer to assist with investigations of the incident, implementation of a performance plan and supervision by an Occupational therapist to observe, assess, shadow and work alongside the staff member when assisting consumers requiring two staff for mobility and transfers.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Compliant with Requirement (3)(e) in Standard 7.

# STANDARD 8 NON-COMPLIANT 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 Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in this Standard. These Requirements were found Non-compliant following a Review Audit conducted 30 October 2019 to 1 November 2019.

The Assessment Team have recommended Requirements (3)(b), (3)(c), (3)(d) and (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s reports and the approved provider’s response to come to a view of compliance with Standard 8 Requirements (3)(b), (3)(c), (3)(d) and (3)(e) and find the service Non-compliant with these Requirements. I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(b) Non-compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The Assessment Team found the organisation did not demonstrate that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services or is accountable for their delivery. This was evidenced by the following:

* As evidenced in Standard 3, some consumers are not receiving clinical care that is best practice or tailored to their needs, and not all consumers are receiving personal care that optimises their health and well-being.
* The clinical governance monitoring framework has recently been introduced through the implementation of generic policies purchased by the organisation.
* Staff are aware of the policies but not familiar with their contents.
* Risk management systems have recently been introduced but not yet implemented. Management advised implementation of the risk management system is currently ‘a work in progress’.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report.

The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Appointment of a Clinical Nurse Manager.
* Renovations have been undertaken to allow extra room for a clinical team.
* Engagement of additional Registered Nurses and activities officers.
* New bus funded and purchased
* The Vice Chairman of the Board attends the service weekly and meets with management.
* A pharmacist who is a sitting member of the Board provides advice on medication management and conducts audits on consumers’ medications.
* Board members attend resident meetings.
* Education to Board members relating to the Quality Standards, reading through one Standard at each meeting and copies of the Quality Standards provided. Additionally, Governance education for Board members was conducted in December 2019.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Assessment Contact the organisation did not demonstrate that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services or is accountable for their delivery.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(b) in Standard 8.

### Requirement 8(3)(c) Non-compliant

*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.*

The Assessment Team found the organisation demonstrated effective governance systems relating to continuous improvement, financial governance, regulatory compliance and feedback and complaints. However, the Assessment Team were not satisfied the organisation demonstrated effective systems relating to information management and workforce governance. This was evidenced by the following:

Information management:

* The service does not have an implemented infection control program inclusive of a COVID-19 management plan or program in accordance with the Communicable Diseases Network Australia (CDNA) guidelines issued 13 March 2020.
* Two care staff said they have not received training on what to do in the event of a COVID-19 outbreak and are not aware of any documentation available to guide them.
* Two care staff said there has been a lot of change at the service, including the implementation of a large number of new documents, such as checklists and forms. The staff said they have not received enough training in the use of the forms to understand what is required of them.
* Four staff said although they are aware the service has purchased new policies and procedures, they said they do not know what they contain or what impact they have on their day to day work as they have not read them or received any training related to them.
* Best practice guidelines regarding clinical deterioration have not been distributed.
* Infection surveillance process documentation is not adequately monitored and rarely includes consumer outcome information.
* Lifestyle staff confirmed that while consumers have been assessed, they have not yet analysed the assessments in sufficient detail to develop an Activities program which is inclusive of all individual consumers’ requirements.

Workforce governance, including the assignment of clear responsibilities and accountabilities

* The organisation did not demonstrate workforce governance is effective to ensure staff receive appropriate training and support to deliver quality care and services to consumers as evidenced in Standard Requirements (3)(c) and (3)(d) and Standard 8 (3)(e).

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report.

The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Improvements include the appointment of a Clinical nurse manager, renovations to the service, additional staff and purchase of a new bus.
* Upgrades to the laundry to improve infection control and ensure continuity of laundry services for consumers
* Purchased an electronic care planning system to improve clinical data management
* Audits of consumer files conducted to ensure information is consistent. This is being monitored by the senior clinical management.
* Implemented process to monitor progress notes to ensure adequate information is entered, incidents are followed up and/or changes in consumers’ care needs occurs
* Staff are undertaking defensible documentation training

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact the organisation did not demonstrate effective information management systems were in place to enable staff to readily access the information they need or an effective workforce governance process to ensure staff receive appropriate training and support to deliver quality care and services to consumers .

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(c) in Standard 8.

### Requirement 8(3)(d) Non-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 found the organisation did not demonstrate it has implemented a risk management framework which includes effective management systems and practices to enable the service to manage high impact or high prevalence risks associated with the care of each consumer. This was evidenced by the following:

* Management said a risk management framework is currently a ‘work in progress’ with risk assessments implemented for the use of restraint.
* The service’s risk register is not complete as yet, including not having completed risk assessments of the buildings, equipment or other aspects of organisational risk. Management advised a risk register is currently being implemented but is incomplete.
* Risks associated with the care of consumers are not appropriately managed or assessed as evidenced in Standard 3 Requirement (3)(b). Issues relating to falls management, risk minimisation and behaviour management were identified by the Assessment Team.
* A generic suite of policies has been purchased by the organisation which include a risk management framework.
* Staff interviewed said they were not aware of the service’s risk management policy and could not describe what it meant for them in a practical sense.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report

The Assessment Team spoke to management in relation to the plan for continuous improvement and were informed no further actions have been taken in addition to the actions reported in the Assessment Contact report dated 7 May 2020.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact the organisation had not implemented a risk management framework to ensure effective management of high impact or high prevalence risks associated with the care of each consumer.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(d) in Standard 8.

### Requirement 8(3)(e) Non-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 found the organisation did not demonstrate it has a clinical governance framework which enables the effective management of infection control. This was evidenced by the following:

* Clinical management stated that, “only in the last few weeks”, a committee has been put together to consider implementation of a COVID-19 management plan. A draft COVID-19 plan has been prepared but not yet been implemented, and an outbreak management team has also only recently been created for COVID-19.
* Two personal care workers interviewed said they have not received training in donning and doffing personal protective equipment. One care staff member demonstrated incorrect procedures for removal of a mask.
* Clinical management said staff have not received training in the use of full personal protective equipment as the service did not have sufficient supplies of gowns, masks or gloves for all staff to practice.
* Clinical management stated the service has approximately 800 sets of personal protective equipment on site and would be reliant on the State Government topping up supplies if they needed them as they have been unable to source any more.
* One personal care worker said they did not feel confident they would be able to safely care for a consumer with COVID-19 and did not know whether the service had an outbreak management procedure or not. They said they had not received any training on this and would be guided by the nursing staff.
* Management said in the event of a consumer presenting with respiratory symptoms the service intends to send them to the local hospital and may refuse to have them return to the service if they are COVID-19 positive.
* The organisation’s policies relating to antimicrobial stewardship, minimising the use of restraint and open disclosure have been purchased from an external provider, are generic in nature and provide little direction to staff with regard to infection control measures or antimicrobial stewardship.
* Two staff said the policies were available in the care station, however, they had not received training in relation to them or read them and so could not give examples of how they would be implemented.

The approved provider’s response consisted of a Plan for continuous improvement and associated documentation. The plan includes planned and completed actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Infection control checklist developed to assist with identification and treatment of consumer infections.
* Antimicrobial stewardship policy and procedure developed.
* Staff training related to antimicrobial stewardship is planned for September/October 2020.

The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies identified at the Review Audit conducted 30 October 2019 to 1 November 2019, including:

* Consumer risk assessments relating to use of restraint demonstrate appropriate consultation is undertaken with the consumer and/or their representative, Medical officers and other relevant persons with regard to the use of bed rails used for safety purposes by consumers.
* Management provided evidence of open disclosure which was confirmed through interviews with consumers and/or their representatives being employed by the service when incidents have occurred.
* Staff practice with regard to infection control was observed to be in accordance with organisational policies and procedures. Staff were observed using sanitising stations, maintaining social distancing where appropriate and utilising personal protective equipment where appropriate.

I acknowledge the approved provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find that at the time of the Assessment Contact the service had not implemented an infection control program inclusive of COVID-19. Feedback from staff indicated they had not had training in relating to personal protective equipment and they would not feel confident to care for someone with COVID-19. Additionally, policies do not provide clear guidelines for staff in relation to antimicrobial stewardship or infection control measures, including measures to follow in the event of an outbreak.

For the reasons detailed above, I find the approved provider, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(e) in Standard 8.

# 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.

**Requirements (3)(a), (3)(b) and (3)(g) in Standard 3**

* Ensure staff have the skills and knowledge to:
* report, document and manage clinical incidents.
* implement appropriate behaviour management strategies to minimise the impact of these behaviours on consumers.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, including management of falls and diabetes are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks.
* Ensure policies, procedures and guidelines in relation to infection control and management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to infection control and management.

**Standard 4 Requirements 3(b)**

* Analyse assessment information and develop an Activities program inclusive of all individual consumer’s’ requirements.
* Provide cultural awareness training for staff.

**Standard 7 Requirements (3)(c) and (3)(d)**

* Ensure staff are provided appropriate training to address the deficiencies identified in four of the eight Quality Standards.
* Ensure training is provided to staff in line with the service’s training schedule and Plan for continuous improvement.
* Ensure attendance at training sessions is monitored and non-attendance managed and addressed.
* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.

**Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8**

* Review the organisation’s governance systems in relation to information management and workforce governance.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers.
* Complete risk assessments and implement an organisational Risk register.
* Ensure policies and procedures in relation to risk are effectively communicated and understood by staff.
* Review policies in relation to antimicrobial stewardship and minimising use of restraint to ensure they provide clear directives for staff.
* Implement a COVID-19 plan and ensure the plan, and outbreak management processes are effectively communicated and understood by staff.
* Review the organisation’s clinical governance framework in relation to Non-compliance identified in Requirements (3)(a), (3)(b), (3)(d) and (3)(g)Standard 3 Personal care and clinical care.