Eyre Peninsula Old Folks Home

Performance Report

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**Commission ID:** 6046

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

**Site Audit date:** 10 March 2021 to 12 March 2021

**Date of Performance Report:** 21 May 2021

# Publication of report

This Performance Report **may be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-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) | Non-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) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Non-compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | 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 Site Audit; the Site Audit 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 Site Audit report received 6 April 2021
* the Assessment Contact - Site Report for the Assessment Contact conducted 11 August 2020 to 12 August 2020
* the Performance Report dated 12 November 2020 for the Assessment Contact – Site conducted 11 August 2020 to 12 August 2020.

# STANDARD 1 COMPLIANTConsumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect and can maintain my identity. I can make informed choices about my care and services and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific Requirements have been assessed as Compliant.

The Assessment Team found overall, sampled consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. The following examples were provided by consumers during interviews with the Assessment Team:

* provided examples of the service supporting them to maintain relationships of choice.
* are comfortable to discuss any culturally specific needs with staff and management if they feel the need.
* are supported to maintain their independence and undertake activities involving risk.
* satisfied with information provided to them.

Initial and ongoing assessment and planning processes assist to identify each consumer’s life history, background interests, spiritual and specific cultural needs. Care plans are developed from information gathered and include strategies to assist staff to provide care and services in line with consumers’ personal needs and preferences. Staff interviewed provided examples of sampled consumers’ personal history, what was important to them and cultural care requirements. Staff described how consumers’ cultural background and needs are considered in the delivery of care and services. The organisation’s policy documents outline the service’s commitment to providing consumers culturally safe services and training records demonstrated Cultural diversity in ageing training has been provided to staff.

Staff described how they support consumers to exercise choice and independence and maintain relationships of their choosing. Care files sampled included information relating to representatives consumers had appointed to participate in decision-making processes relating to their care. Care files also demonstrated consumers and representatives are consulted in relation to changes in consumers’ health and well-being.

Consumers are provided information through a variety of avenues, such as meeting forums. One visually impaired consumer described how staff provide them with information, including spending time to read correspondence out aloud. Another consumer stated communication within the service had improved, they now feel listened to and staff take time to ensure they understand. Additionally, consumers and representatives were satisfied consumers’ privacy is respected and personal information kept confidential. This was also supported through observations of staff practice and the service environment.

Staff and management demonstrated an awareness of consumers’ right to take risks and their responsibility to assist consumers to do so. Staff described activities consumers chose to undertake which include an element of risk. Risk assessment and management plans are completed in consultation with consumers where activities they choose to partake include an element of risk; assessments are completed, risks identified and risk mitigation strategies implemented.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, Compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANTOngoing 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 Non-compliant as one of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(e). I have provided reasons for my finding in the specific Requirement below.

The Assessment Team found overall, consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* have been involved in assessment and planning phase and confirmed nursing staff discuss consumer care plans with them.
* described how consumers, and the people important to them are involved in assessment and planning.
* confirmed involvement when changes are made to consumers’ care and service plan and they understand these changes.

Initial and ongoing assessments assist the service to identify each consumer’s goals, care needs and preferences. A range of validated assessment tools are used, including those to identify risks to consumers’ health and well-being. Consumer files sampled included risk assessments for falls, pressure injuries and malnutrition. Care plans are developed and those sampled by the Assessment Team were current, reflective of consumers’ assessed needs and were noted to be written from the consumers’ perspective. Care staff sampled were familiar with consumers’ needs goals and preferences and described how they consult with consumers on a daily basis to ensure these remain current.

Consumers and representatives confirmed they are involved in assessment and care planning processes. Additionally, consumers and representatives confirmed they are consulted in relation to assessment outcomes and changes to care. Care files sampled demonstrated other providers of care and services, such as Medical officers and allied health specialists, are involved in consumers’ care. Consumers sampled expressed satisfaction with access to other providers of care.

Care plans are available to consumers and/or representatives on request. Consumers and representatives were aware of care plan documents and confirmed care plans had been discussed with them, including where changes to care plans had occurred. Care staff have access to care plans to assist to deliver care and services to consumers. Additionally, clinical staff confirmed changes to consumers’ care and service needs are communicated through handover processes.

The service has processes to ensure care plans are regularly reviewed, however, the Assessment Team were not satisfied the service demonstrated this process consistently occurs. Specifically, in relation to pain, behaviour and sleep for one consumer.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Non-compliant with Requirement (3)(e) and Compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

## 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.*

### 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.*

### 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.*

### 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.*

### Requirement 2(3)(e) Non-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.*

The Assessment Team were not satisfied the service adequately demonstrated care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on consumers’ needs, goals or preferences. Evidence provided by the Assessment Team related to sleep, pain and behaviour management for one consumer. This was evidenced by the following:

* Sleep was not being monitored to support effective evaluation and determine efficacy of pharmalogical interventions which were being trialled. Sleep charting or assessments were not initiated to monitor effectiveness of medication during the trial period.
	+ Clinical staff stated the electronic care planning system did not have a sleep chart option and, therefore, staff were relying on information provided during handover to determine effectiveness of interventions.
	+ There was no further documentation to support monitoring of consumers’ sleep patterns since implementation of the electronic care system in January 2021.
* Effectiveness of medication was only documented in the progress notes on one occasion during the seven day trial period.
* Care and clinical staff stated the consumer regularly refuses care and displays verbal aggression towards staff and this has been ongoing for some time. Staff also indicated pain is a contributing factor.
* Clinical staff stated pain assessment are continuous, however, over a three day period, the consumer’s pain was only documented on three occasions with two of these noting the consumer to be experiencing pain.
	+ Pain charting was not conducted in line with the service’s clinical guidelines which indicate consumers are to be assessed for a period of seven days.
* Progress notes did not indicate an evaluation on completion of pain charting was completed to determine if pain was being managed or if pain was a factor for increased behaviours.
* Behaviour charting over a 15 day period included eight incidents of challenging behaviours. Four of the eight entries did not include interventions initiated.
* Care plan documentation has not been updated in response to pain charting or increasing episodes of challenging behaviours.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions, however, the person responsible, planned completion date and outcomes sections of the Plan are blank. Associated documentation provided included, but is not limited to:

* Pain assessment completed and the consumer’s care plan updated, including management interventions for pain and behaviour.
* Completed a case conference with the consumer’s representative.
* Progress notes provided indicate effectiveness of pharmalogical interventions is being monitored.
	+ For the period post Site Audit, on three occasions where medication is noted as having nil to minimal effect, further description of the consumer’s demeanour or interventions initiated are not documented.
* Conducted a sleep audit which indicated 100% compliance. The audit process included interviews with consumers and staff and processes. The audit schedule for 2021 indicates the audit is conducted annually.
	+ No supporting commentary or audit trail has been documented on the audit document to indicate consumer files sampled as part of the audit.

I acknowledge the provider’s response, the associated documentation provided and the actions initiated in response to the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, for the consumer highlighted, charting and assessments were not consistently initiated and evaluated. The consumer’s care plan was not consistently reviewed to ensure strategies relating to sleep, behaviour and pain were up-to-date. Additionally, the consumer’s care plan was not reflective of charting and assessment outcomes and the consumer’s current care and service needs.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, Non-compliant with Requirement (3)(e) in Standard 2.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant.

The service was found Non-compliant with Requirements (3)(a) and (3)(b) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. Issues identified related to management of diabetes, falls and behaviour. The service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirements below. However, at the Site Audit, the Assessment Team were not satisfied the service demonstrated effective management of consumer wounds, diabetes and weights. The Assessment Team have recommended Requirements (3)(a) and (3)(b) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(b). I have provided reasons for my findings in the specific Requirements below.

The service was found Non-compliant with Requirement (3)(g) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. In response to the Non-compliance, the service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below.

In relation to Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g), the following comments were provided by consumers during interviews with the Assessment Team:

* Confirmed they were satisfied with personal and clinical care provided and felt their needs and preferences were known by staff.
* Have observed staff washing their hands regularly.
* Are satisfied with the cleanliness of their rooms.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. A consumer file sampled included and end of life care plan identifying the consumer’s needs and supports required to make them comfortable. Additionally, spiritual well-being, equipment needs, pain management and personal preferences during the terminal phase of care had been identified. Staff sampled described how they monitor consumers’ comfort during the palliative phase and described care implemented, including regular review of pain, repositioning and massage.

Documentation viewed demonstrated where consumers were noted to have deteriorated or changes to their mental health or cognitive or physical function were identified, actions were initiated in a timely manner and referrals to Medical officers or allied health specialists were undertaken. Additionally, reassessments occur, and care plans are updated to reflect the consumer’s current care needs.

The service demonstrated timely and appropriate referrals occur in response to changes in consumers’ health and well-being. Consumer files sampled demonstrated Medical officers and a range of allied health specialists are involved in the care of consumers. Consumers and representatives sampled stated consumers have access to Medical officers and other relevant health professionals when they need them.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Non-compliant with Requirement (3)(a) and (3)(b) and Compliant with Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### 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 were not satisfied the service demonstrated each consumer gets safe and effective personal care or clinical care that is best practice, tailored to their needs and optimises their health and well-being. Deficiencies identified related to management of wounds and diabetes for five consumers. This was evidenced by the following:

* Four wound charts for three consumers did not consistently include wound length, width or depth.
	+ Management stated it is an expectation that the wound chart is completed in full.
* Evaluation of the wound and dressing regime to determine wound status or changes to the dressing regime was not consistently completed on the additional information section of wound charts for all three consumers.
	+ Management stated the additional information section is used to evaluate wound and dressing regimes.
* Wound imagery did not clearly distinguish the length, width and depth of wounds on all occasions for all three consumers.
* Wounds were not consistently reviewed on the next review date specified on wound charts for all three consumers.
* Actions were not initiated for blood glucose levels outside of range in line with the Diabetic management plan directives for one consumer. These directives included communicating with the Medical officer, monitoring blood glucose and ketone levels and encouraging fluids.
* For another consumer, blood glucose levels were outside of reportable range on 40 occasions over a period of 70 days.
	+ Actions taken in response to levels outside of range were not in line with Medical officer directives.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions, the person responsible and planned completion date. Planned actions include:

* Weekly audits of wound charting.
* Education to be provided to staff in relation to wound charting, diabetes.
* Memoranda to staff reminding of diabetes and wound protocols.

The service was found Non-compliant with Requirement (3)(a) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found diabetes and falls management processes were not in line with best practice care. Additionally, communication processes by staff for one consumer did not demonstrate their health and well-being was being optimised. The Assessment Team’s report for the Site Audit provided evidence of actions taken to address deficiencies, including, but not limited to:

* Completion of a Communication assessment and strategies for one consumer.
* Completed Diabetes management plans for diabetic consumers.
* Updated the Diabetes management policy.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation did not demonstrate wound management documentation was consistently completed and directives for blood glucose levels out of range actioned.

In relation to wound management, evidence in the Assessment Team’s report demonstrates consumers’ wound treatment records were not consistently completed, including measurements of length, width and depth of wounds and evaluation of wound and dressing regime. Additionally, wounds were not consistently reviewed in line with the next review date. I acknowledge for consumers highlighted in the Assessment Team’s report, wounds appear to be healing and/or resolved. However, I have placed weight on information provided to the Assessment Team by management confirming completion of the wound chart in full is an expectation. I have also considered that staff have recently been provided training in relation to wound documentation in the new electronic care system, however, all wound chart fields are still not being consistently completed. I find it reasonable for consumers to expect their wounds are monitored at each treatment, including consideration of measurements and evaluation of the wound and dressing regime, in line with the service’s processes and best practice. Such practices would ensure wound progression is monitored and wound deterioration is identified in a timely manner.

In relation to blood glucose monitoring, I have placed weight on information provided by the Assessment Team indicating blood glucose levels outside of range, were not actioned in line with Medical officer directives. I acknowledge for consumers highlighted in the Assessment Team’s report, consumers did not experience adverse outcomes in response to the out of range blood glucose levels. However, I have placed weight on information in the Assessment Team’s report indicating both consumers had Diabetic management plans in place with specific directives documented by the Medical officer. I find it reasonable for consumers to expect where blood glucose levels are out of range, Medical officer directives are followed and additional monitoring of the consumer implemented, in line with the service’s process and best practice.

I have also considered deficits in relation to diabetes management were identified at the Assessment Contact conducted 11 August 2020 to 12 August 2020. Whilst improvements were implemented by the service in response to the Non-compliance identified in this Requirement, these improvements have not been effective in ensuring appropriate actions are initiated in response to blood glucose levels out of range.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, 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 were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically in relation to weight management for two consumers. This was evidenced by the following:

Consumer A

* Weight records sampled indicate a wight loss of 7.9kg over a six month period. The weight loss had not been evaluated or management strategies updated or developed to mitigate risk of continued weight loss.
* Observations indicated Consumer A appeared frail and thin. Consumer A was observed holding up their trousers with staff stating, “you need to hitch up those pants, they are falling off of you”.
* Staff sampled stated Consumer A:
	+ sleeps all day and is awake at night.
	+ does not always receive their nutritional supplement or meals.
	+ gets hungry at night and they can heat up food and check to see if staff have left a meal in the fridge for the consumer. Catering staff stated they do not prepare or provide additional meals for the consumer to access at night.
* A Nutritional assessment indicates Consumer A progressed from at risk of malnutrition to malnourished. However, risks identified did not prompt a referral to a Dietitian or reassessment or review of nutrition and hydration management strategies.
* A recent care plan evaluation indicated current nutrition and hydration strategies were successful.
* Management acknowledged weight loss and stated Consumer A’s family and Medical officer had decided not to proceed with a Dietitian referral.

Consumer B

* Consumer B provided the following feedback to the Assessment Team:
	+ are concerned about their weight; would like to eat more but does not always like the food and has not been offered alternative food choices.
	+ cannot close their hand around utensils and would like staff assistance with meals. Staff will assist with a few mouthfuls of food and leave as they (Consumer B) are so slow.
	+ does not like the fluid nutritional supplements provided as they are milky and they prefer the fruit flavoured supplement. Consumer B stated they had discussed these preferences with staff but continued to receive the “milky one”.
* Pre-entry information indicated Consumer B was malnourished, however, this information was not used to develop a clinical monitoring plan to oversee the effectiveness of risk mitigation strategies relating to weight loss.
	+ Weight records sampled indicate a wight loss of 5.2kg over a two month period.
* Staff sampled stated they have not been directed to monitor Consumer B’s food or fluid intake.
* Clinical and care staff sampled stated Consumer B has gained weight since entry and continued to do so.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions for both consumers, however, the person responsible and planned completion date sections of the Plan are blank. Documentation provided demonstrated:

In relation to Consumer A

* A progress note entry dated September 2020 indicates a discussion with the consumer’s representative about Consumer A’s weight loss. The entry states representative ‘is happy not to have any allied health input (Dietitian) and to continue with current interventions’.
* A Medical officer notation dated September 2020 indicating ‘Not for Dietitian input. Family agrees’.
* A nutritional risk assessment indicating Consumer A is at risk of malnutrition.

In relation to Consumer B

* A Dietetics Handover dated the day prior to Consumer B entering the service describing the consumer as severely malnourished; food intake increased marginally and ‘thoroughly enjoyed and become heavily reliant’ on oral nutritional support. Weight was noted to have increased and significantly improved due to compliance with oral nutritional support. Recommendations included to provide fruit based oral nutritional supplements three times a day.

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found falls and behaviour management were not being effectively managed for each consumer. The Assessment Team’s report for the Site Audit provided evidence of actions taken to address deficiencies, including, but not limited to:

* Training provided to staff relating first aid and manual handling.
* Developed a Falls committee to target high risk consumers.
* Provided Falls and Risk assessment protocols to staff.
* Reviewed all care plans to ensure risks were documented as part of the implementation of the electronic care system.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, I find risks associated with nutrition and hydration and weight management relating to two consumers have not been appropriately identified, responded to or managed.

In relation to Consumer A, the provider’s response asserts the consumer’s family and Medical officer do not wish for allied health input. However, documentation included as part of the provider’s response demonstrates this directive occurred six months prior to the Site Audit and in this time weight records indicate Consumer A has lost a further 4.6kg. Additionally, a recent nutritional assessment indicates the consumer is at risk of malnutrition. Further consultation with Consumer A’s family and the Medical officer has not occurred in response to Consumer A’s continuing weight loss and risk of malnutrition. Additionally, management strategies have not been reviewed or additional strategies implemented to mitigate continuing weight loss and risk of malnutrition. I have also placed weight on information provided in the Assessment Team’s report indicating Consumer A was observed to be thin and frail with staff feedback indicating Consumer A does not always receive meals or nutritional supplements.

In relation to Consumer B, information was included in the provider’s response to demonstrate the consumer had a ‘long standing history of malnourishment prior to admission’. However, I have considered whilst the service had information from an allied health specialist, dated the day prior to Consumer B entering the service, indicating Consumer B was at risk of malnutrition and weight loss, this information was not used by the service to develop management and monitoring strategies to minimise the known risks and allied health recommendations were not consistently implemented. Consumer B recorded a weight loss of over 5kg in the two months preceding the Site Audit and a recent assessment indicates the consumer is malnourished. I have also placed weight on information provided to the Assessment Team by Consumer B indicating they are concerned about their weight, are provided milk based nutritional supplements and they are unable to remain sufficiently independent with mealtime activities.

Whilst actions in relation to Consumer B were taken by the service, such as consultation with Consumer B, care plan updates, referral to a Dietitian and nutrition and risk assessments, these were not initiated until issues relating to Consumer B were raised with the service by the Assessment Team.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, 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.*

### 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.*

### 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.*

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

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

### Requirement 3(3)(g) 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 service was found Non-compliant with Requirement (3)(g) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found policies did not provide sufficient information in relation to minimising antibiotic use or reference COVID-19. Additionally, processes for monitoring consumer infections did not sufficiently provide information to indicate follow-up of consumers had occurred following completion of antibiotics. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Updated the Infection control policy to include COVID-19 and requirement to wear face masks.
* Updated the Infection control checklist to include COVID-19 (add full stop)
* All clinical, care and ancillary staff have completed annual compulsory competencies in relation to aspects of infection control.
* Updated the Antimicrobial stewardship policy and training in relation to antimicrobial stewardship has been provided to staff.
* An Infection control lead has been appointed.

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

Consumers sampled stated staff adhere to infection control practices, including washing their hands regularly and their bedrooms and bathrooms are regularly cleaned. These staff practices were observed by the Assessment Team during the Site Audit. A consumer care file sampled demonstrated appropriate follow up of a consumer following completion of antibiotics for an identified infection.

The service has an outbreak management plan and clinical supplies which are accessible to staff in the event of an outbreak. An influenza vaccination program is in place and documentation viewed demonstrated all staff and consumers have received the vaccination.

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

# STANDARD 4 NON-COMPLIANTServices 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 Quality Standard is assessed as Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(e). I have provided reasons for my finding in the specific Requirement below.

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. In response to the Non-compliance, the service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below.

In relation to Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(f) and (3)(g), the Assessment Team found overall, consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. The following examples were provided by consumers during interviews with the Assessment Team:

* satisfied with provision of care and services in relation to emotional, spiritual and psychosocial support.
* do things of interest them and maintain social and personal relationships.

Assessment processes assist to identify each consumer’s goals, needs and preferences, including in relation to spiritual, cultural and lifestyle aspects. This information was noted to be reflected in care plans sampled. For sampled consumers, staff described what was important to consumers, how they support consumers to remain independent ensuring their safety and how they support consumers’ emotional well-being.

The lifestyle program includes a range of activities and staff sampled described activity preferences and support strategies for individual consumers. Changes to the activities program occurs, including in response to feedback from consumers at meeting forums. Staff described how consumers are supported to participate in the community and maintain friendships.

A sample of consumer files viewed by the Assessment Team demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared. Staff sampled stated they have access and/or are provided with relevant information about consumers to enable delivery of care and services.

The service has processes to identify consumers’ nutrition and hydration requirements and meals were observed to be provided to consumer in line with assessed needs. The service has a rotating menu which includes meals of suitable quality and quantity. Overall, sampled consumers and representatives stated they were satisfied with meals provided. Documentation sampled demonstrated consumers can provide feedback on the menu through feedback mechanisms and meeting forums.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Non-compliant with Requirement (3)(e) and Compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living.

## 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.*

### Requirement 4(3)(b) Compliant

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

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found assessment information had not been analysed to assist with implementation of an activities program inclusive of all consumers’ requirements. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including, but not limited to:

* All staff have completed Cultural diversity in ageing training.
* Lifestyle evaluations have been completed for all consumers.
	+ Care files sampled by the Assessment Team included completed evaluations as well as activity and religious activity attendance information.
* Implemented a review process which will include analysis of lifestyle assessments and care plans in line with care plan review processes.

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

Consumers and representatives sampled were satisfied with the provision of care and services relating to consumers’ emotional, spiritual and psychological support.

Care files viewed included examples support provided to consumers and representatives, including for a consumer in the palliative phase of care and a new consumer who entered the service. Staff provided examples of how they support consumers’ emotional, spiritual and psychological well-being and stated they had been provided training in relation to Cultural awareness.

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

### 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.*

### 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.*

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

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

The Assessment Team were not satisfied the service demonstrated appropriate referrals to individuals, other organisations and providers of other care occur in line with the intent of the Requirement under Standard 4. This was evidenced by the following:

* Management were unable to provide any examples of referrals or consideration for a referral within the last 12 months in relation to services and supports for daily living.
* Management and lifestyle staff provided examples of referrals for clinical matters and appeared unaware this Requirement related to referrals of a non-clinical nature.
* Management were unaware of contacts of other services and supports in the community or State.
	+ Management confirmed there are two ‘men’s sheds’ in the local community, however, no consumers had been referred or considered for referral to this service. Lifestyle staff stated they were not sure which consumers would like to attend this service.
* The service has a referral policy in relation to Requirement (3)(e). Lifestyle and clinical staff were unaware of the policy.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. However, Requirement (3)(e) in Standard 4 was not referenced in the Plan. Documentation provided in the response included Lifestyle assessments for five consumers, a bus trip list and an activities chart for one consumer demonstrating a trip to the library.

I acknowledge information included as part of the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service could not demonstrate referrals are initiated to individuals, other organisations and providers of other care and services in line with the intent of Requirement (3)(e) in Standard 4. I have placed weight on information in the Assessment Team’s report indicating management and staff were unable to provide examples of referrals, other than clinical referrals, which had occurred within the last 12 months in response to consumers’ changing service and support needs. Additionally, management and staff were unaware of other services and supports in the local community or State. I have also considered that information included in the provider’s response did not demonstrate the need for referral is identified and referrals to other organisations and providers of other care and services occur to ensure the diverse needs of consumers are met.

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANTOrganisation’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 Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they feel they belong in the service and feel safe and comfortable in the service environment. The following examples were provided by consumers during interviews with the Assessment Team:

* feel the service environment is safe, welcoming and easy to navigate.
* can access outdoor areas whenever they choose.
* maintenance staff are prompt to requests made.
* feel safe when using clinical equipment and staff are competent with using the equipment.

The Assessment Team noted the environment was welcoming, easy to navigate, and had a home like feel and consumer rooms were decorated with consumers’ personal belongings. Dining and activity areas were equipped with comfortable, suitable furnishings with ample room for consumers to mobilise and congregate. Consumers were observed sitting and/or walking through the large lawn area, gardens and courtyard areas. Consumers were observed moving freely both indoors and outdoors. Additionally, the indoor environment provides sufficient room for consumers to mobilise safety and independently.

The environment was observed to be safe, clean and well maintained with appropriate external and internal secured entrances. Staff described how maintenance tasks are reported and stated requests are responded to; this was supported by maintenance documentation sampled. External contracted service providers assist in monitoring and maintaining the building and equipment. Cleaning staff are guided by a cleaning schedule ensuring all areas of the service and furniture, fittings and equipment are cleaned on a regular basis. Cleaning processes are in place and cleaning staff were observed to carry out their duties throughout the Site Audit.

The Assessment Team found the organisation has monitoring processes to ensure a safe and comfortable service environment is provided that promotes consumers’ independence, function and enjoyment.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, Compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### 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.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT 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 Quality Standard is assessed as Compliant as four of the four specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered they are encouraged and supported to give feedback and make complaints, and appropriate action is taken. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* feel supported to provide feedback and make complaints and feel comfortable to discuss any issues directly with staff or management or raise issues at meeting forums.
* the Chief executive officer has an open door policy and they can go and discuss anything with them.
* satisfied the service would initiate actions as a result of feedback.
* provided an example of an improvement implemented in response to feedback.

Consumers are provided with information about internal and external complaint avenues and advocacy on entry. The Assessment Team observed feedback forms and complaints and advocacy information displayed and readily accessible. Additionally, this information was noted to be available in languages other than English. Suggestion boxes are located throughout the service to enable consumers to submit feedback anonymously. Staff sampled described how they would respond if a consumer raised an issue or concern, including consumers with cognitive impairments or language barriers.

Consumers felt confident the service would take action in response to their feedback and stated actions relating to complaints are discussed at consumer meeting forums. Management discussed processes for resolving complaints received and stated they work closely with all parties to achieve resolution in a timely manner. Staff demonstrated an awareness of open disclosure processes and incident reports sampled demonstrated open disclosure processes had been applied.

The service demonstrated how complaints are reviewed and used to improve the quality of care and services. A complaints register is maintained, and documentation sampled by the Assessment Team demonstrated actions are taken as a result of feedback. A Priority action workplan viewed by the Assessment Team included improvements resulting from suggestions from consumers and staff.

The Assessment Team found the organisation has monitoring processes to ensure input and feedback from consumers, carers, the workforce and others is sought by the service and used to inform continuous improvements for individual consumers and the organisation.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, Compliant with all Requirements in Standard 6 Feedback and complaints.

## 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.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

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

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

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

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements have been assessed as Non-compliant.

The service was found Non-compliant with Requirement (3)(c) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. Issues identified included staff not being provided training in key clinical areas. The service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below. However, at the Site Audit, the Assessment Team were not satisfied actions implemented have effectively addressed the deficits identified and have recommended Requirement (3)(c) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(c). I have provided reasons for my finding in the specific Requirement below.

The service was found Non-compliant with Requirement (3)(d) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. In response to the Non-compliance, the service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below.

In relation to Requirements (3)(a), (3)(b) and (3)(e), consumers sampled considered they get quality care and services when they need them and from people who are capable and caring. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* there are enough staff to meet consumers’’ clinical and care needs.
* staff are kind, caring and treat them with respect.

The Assessment Team were satisfied the service demonstrated how the workforce is planned and the number and mix of staff deployed enables delivery of quality care and services. There are processes to ensure the skill mix of staff is considered in addition to staffing level, based on occupancy rates and acuity of consumers. There are processes to manage staffing shortfalls. Most staff sampled stated they have sufficient time to undertake their duties.

Staff were observed interacting with consumers in a kind, caring and respectful manner and were observed not to rush consumers. Consumers stated staff are responsive to their needs and understand their preferences and interests.

A staff performance appraisal and development process is in place, including for new and existing staff. Management stated they monitor staff performance through observation, handover processes, clinical indicators, call bell response times and feedback processes. Additionally, where poor staff performance is identified, performance management processes are initiated. Staff sampled confirmed they are supported through the performance review process.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Non-compliant with Requirement (3)(c) and Compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### 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 were not satisfied the service demonstrated staff are competent in relation to consumers’ clinical care needs, including management of pain, behaviours, wounds, weight and diabetes. This was evidenced by the following:

* Care and services were not reviewed or evaluated for effectiveness and used to drive assessment processes in relation to consumers’ pain and behaviour management.
	+ Clinical staff sampled stated they are responsible for completing evaluations.
* Wound documentation and evaluation was not consistently completed in line with the service’s processes for three consumers. Practices relating to wound documentation was not in line with the service’s processes.
	+ Staff have been provided with training in relation to wound documentation using the electronic system.
* Weight management, including evaluation and review of strategies was not effectively demonstrated for two consumers.
* Blood glucose levels outside of desired range were not actioned in line with Medical officer directives for two consumers.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions, however, in relation to Standard 7, the person responsible, planned completion date and outcomes sections of the Plan are blank. Documentation provided indicates:

* Weight management training has been provided to 16 clinical staff.
* Two completed wound audits demonstrating monitoring of staff compliance with wound charting.

The service was found Non-compliant with Requirement (3)(c) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. The service was found not to demonstrate training, specifically in relation to key clinical areas had been provided to staff, staff had not received training in correct use of personal protective equipment and were not confident they would know what to do in the event of an outbreak. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Annual compulsory competencies have been completed by all staff, including:
	+ Protocols provided relating to pain, weight loss and malnutrition
	+ Practical competencies completed related to continence management, recognising deterioration and pain, wound and medication management.
	+ Education sessions attended by care and clinical staff relating to wound and continence care.
	+ Promotion of Wound Awareness week, including providing links to online training.
* Implemented regular COVID-19 meetings with the outbreak management team. The COVID outbreak management plan has been discussed at staff.
* Conducted COVID outbreak drills to determine staff readiness and understanding of actions to take in the event of an outbreak.
* All clinical, care and ancillary staff completed annual compulsory competencies in relation to infection control.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation did not demonstrate the workforce were delivering clinical care in line with the organisation’s processes. Additionally, the service’s monitoring processes had not been effective in identifying deficits related to staff management of consumers’ diabetes, wounds, pain, weight and behaviours identified by the Assessment Team. I have also considered that whilst staff have received training and/or information in relating to wound care, weight management, diabetes and pain, issues relating to assessment, review, evaluation and follow-up of these key clinical areas continue to occur.

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

### Requirement 7(3)(d) Compliant

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

The service was found Non-compliant with Requirement (3)(d) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. Issues identified related to the service not being able to demonstrate staff had been provided with sufficient, ongoing training and the mandatory training program not being maintained. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Designed annual compulsory competency sheets for clinical and care staff detailing training, including quizzes, documents to read, practicals competencies and group sessions to be completed.
* All clinical and care staff have completed compulsory annual competencies within the timeframe specified.
* All staff have completed manual handling training.

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

All consumers sampled were satisfied with staff skills and knowledge and stated they felt safe when receiving assistance from staff.

The service has a comprehensive orientation and induction process which includes buddy shifts and job specific mandatory training components. An ongoing, mandatory training program, including compulsory competencies, is provided and staff sampled indicated a varied training program is provided through a variety avenues, including online, meeting forums, memoranda and informal communications. A training register viewed by the Assessment Team demonstrated all staff had completed the annual training program within specified timeframes.

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

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

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

The service was found Non-compliant with Requirements (3)(c) and (3)(e) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. Deficiencies identified included the organisation not demonstrating effective information management and workforce governance processes, the service not having implemented an infection control program inclusive of COVID-19, staff not being sufficiently trained and policies not providing clear guidelines in relation to antimicrobial stewardship or infection control measures. In response to the Non-compliance, the service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirements below.

However, at the Site Audit, in relation to Requirements (3)(c) and (3)(e), the Assessment Team were not satisfied the service demonstrated effective governance systems relating to regulatory compliance or an effective clinical governance framework is in place. The Assessment Team have recommended Requirements (3)(c) and (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(c) and (3)(e). I have provided reasons for my findings in the specific Requirements below.

The service was found Non-compliant with Requirements (3)(b) and 3(d) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020. In response to the Non-compliance, the service and organisation has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirements below.

Overall, sampled consumers considered the organisation is well run, and they can partner in improving the delivery of care and services. All consumers and representatives sampled were satisfied with the service, they have input into how services are delivered and felt supported by the service

In relation to Requirement (3)(a), the Assessment Team found the service demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Consumers are supported to provide feedback through a number of avenues, including meeting forums, surveys, feedback mechanisms and care plan review processes. Additionally, consumers are made aware of improvement initiatives implemented by the service through newsletters and meeting forums.

Based on the evidence documented above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Non-compliant with Requirements (3)(c) and (3)(e) and Compliant with Requirements (3)(a), (3)(b) and (3)(d) in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

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

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found the organisation did not demonstrate that the organisation’s governing body promoted a culture of safe, inclusive and quality care and services or was accountable for their delivery. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including, but not limited to:

* The organisational Risk register demonstrated key areas of risk to the service have been identified, including staffing and financial risks. Strategies to minimise potential impact to the service have been documented.
* Provided policies and procedures to staff, relevant to their role.
* Management said significant complaints are communicated to the Board through reporting mechanisms.
* Clinical data is communicated to the Board through monthly reports.

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

The service demonstrated how the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Documentation viewed by the Assessment Team demonstrated the Board has driven a number of improvements and seeks information from the service to ensure the Quality Standards are met.

Board members come from a range of professions, including clinical, financial and business backgrounds. Board member induction includes an information pack outlining information on the Quality Standards. The Chairman of the Board attends the service weekly and Board members regularly attend consumer and representative meeting forums.

Reporting from the service to the Board occurs and includes significant complaints and clinical incident data.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Compliant with Standard 8 Requirement (3)(b).

### 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 organisation demonstrated effective organisation wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. However, the Assessment Team were not satisfied the service adequately demonstrated effective governance systems in relation to regulatory compliance, specifically compulsory reporting. This was evidenced by the following:

* An incident in relation to unreasonable use of force by a staff member against a consumer was not recognised by management or reported in line with legislative requirements. The incident was witnessed by two clinical staff.
* Documentation indicated the incident was investigated and the staff member placed on a first and final warning.
* The Chief executive officer stated they did not believe the incident was serious enough to warrant reporting to the Department of Health and the Police.
* There are no specific monitoring processes to ensure reportable assaults are identified and actioned in line with legislative requirements.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions at a Standard level, however, in relation to Standard 8, the person responsible, planned completion date and outcomes sections of the Plan are blank.

The service was found Non-compliant with Requirement (3)(c) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found the service did not demonstrate effective information management systems or workforce governance processes. The Assessment Team’s report for the Assessment Contact provided evidence of actions taken to address deficiencies, including:

* Establishing a COVID-19 management team.
* Developing an infection control program inclusive of COVID-19. This included review and development of a COVID-19 policy and updating the Infection Control Policy to include information on the management of COVID-19.
* Discussed a range of policies through staff meeting forums and provided policies and procedures to staff, in line with their role.
* Developed a competency assessment document to monitor education completed, policies provided and professional registration. This includes information provided to staff in relation to falls, pain, weight loss and malnutrition, risk assessments, recognising deterioration and medication management.
* Developed a best practice information folder which is accessible to all staff.
* All staff have completed the required donning and doffing training.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation did not demonstrate an understanding of legislative requirements relating to compulsory reporting. An incident witnessed by clinical staff, was not reported in line with compulsory reporting requirements. The Chief executive officer stated they did not deem the incident serious enough to warrant reporting. The Assessment Team’s report also notes the mandatory reporting folder for the six months preceding the Site Audit indicated no other reportable incidents or discretion not to report incidents had been identified. Additionally, I have considered that the provider’s response did not include any supporting evidence or documentation to dispute the deficiencies identified by the Assessment Team.

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

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can.*

The service was found Non-compliant with Requirement (3)(d) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found the organisation had not implemented risk management framework to ensure effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including, but not limited to:

* The organisational Risk register identifies key areas of risk to the service and strategies to minimise the potential impact to the service.
* Implemented a risk assessment for consumers who choose to undertake risky activities.
* Provided information to staff relating the Risk assessment protocol and provided staff training on dignity of risk.
* Provided the Falls protocol to staff which they were required to read and sign.
* All staff have completed manual handling training.
* Implemented a Falls management committee.
* Reviewed consumer care plans to ensure relevant risks were identified and planned for.

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

The organisation has a documented risk management framework which includes high impact or high prevalence risks associated with the care of consumers is managed; the abuse and neglect of consumers is identified and responded to and consumers are supported to live the best life they can. The framework is underpinned by a range of policies and procedures. Staff sampled stated they were aware of the policies relating to the framework and provided examples of their relevance to their work.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, in relation to Eyre Peninsula Old Folks Home, to be Compliant with Standard 8 Requirement (3)(d).

### 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 were not satisfied the organisation demonstrated the clinical governance framework was effective. This was evidenced by the following:

* Three Clinical summaries sampled included collation of incident numbers. However, no actions or analysis to identify trends in incident data had been documented. Increases in urinary tract infections and wounds were noted by the Assessment Team.
* The number of infections each month are captured. However, reporting does not indicate antibiotic use and management stated monitoring of antibiotics prescribed to identify trends does not occur.
* A register of consumers prescribed psychotropic medication is maintained. However, information is not analysed to trend medication usage.
* Effective oversight of the new electronic care system has not occurred. Issues identified by the Assessment Team included:
	+ Sleep charting not being completed as there is no capacity for this to occur in the electronic system.
	+ Completion of wound management charts is inconsistent.
	+ Ideal weight ranges have been incorrectly identified.

The provider’s response consisted of a Plan for continuous improvement (the Plan) and associated documentation. The Plan included a brief description of planned actions at a Standard level, however, in relation to Standard 8, the person responsible, planned completion date and outcomes sections of the Plan are blank. Documentation provided included:

* Two clinical and antibiotic therapy monitoring reports outlining signs and symptoms of infection, location, type of infection and medication and additional measures initiated.
* Reporting processes initiated to track psychotropic medications prescribed and usage on a monthly basis. This will be monitored through regular meeting forums.
* Commenced monitoring of consumers’ psychotropic medication usage with data used to identify opportunities to reduce medications.

The service was found Non-compliant with Requirement (3)(e) following an Assessment Contact – Site conducted 11 August 2020 to 12 August 2020 where it was found the organisation had not implemented an infection control program inclusive of COVID-19 and policy documents did not provide clear guidelines in relation to antimicrobial stewardship or infection control measures. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including, but not limited to:

* Establishing a Covid-19 management team which meets on a monthly basis and reports on COVID-19 through a clinical staff meeting forum.
* Developing an infection control program inclusive of COVID-19. This included review and development policy documents.
	+ Clinical staff sampled demonstrated an awareness of the infection control program and actions to take in the event of an outbreak.
* All staff have completed personal protective equipment donning and doffing training.
* Developed and implemented policies in relation to antimicrobial stewardship, minimising use of restraint and open disclosure.
* Training in relation to open disclosure provided to staff.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation’s clinical governance framework was not effective. Clinical incident data was not being used effectively to identify trends and improvement opportunities relating to consumer care. Whilst a register of psychotropic medications prescribed was in place, use of psychotropic medication was not being actively monitored or actions to minimise the use of these medications overall initiated. I have also considered that whilst a new electronic care system has been implemented, effective oversight of this has not occurred. Issues relating to charting, wound management documentation and weight ranges had not been identified by the service.

For the reasons detailed above, I find Eyre Peninsula Old Folks Home Inc, 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.

**Standard 2 Requirement 3(e)**

* Ensure staff have the skills and knowledge to:
	+ recognise changes to consumers’ health and well-being and initiate assessments, implement and/or review strategies and monitor effectiveness.
	+ initiate assessments and update care plans where changes to consumers’ health are identified or when incidents occur.
* Ensure consumer care plans are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
	+ appropriately assess, review, evaluate and monitor consumer wounds in line with documented plans and document all required information in the electronic care system.
	+ monitor consumers’ blood glucose levels in line with Medical officer directives and implement appropriate monitoring strategies where readings are outside of acceptable ranges. This includes notifying Medical officers.
	+ recognise changes to consumers’ health and well-being, including weight loss, implement appropriate management strategies and initiate referrals to Medical officers and/or allied health specialists.
	+ initiate assessments, develop appropriate management strategies and monitor effectiveness of strategies relating to weight loss.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, including management of wound, weights and specialised nursing care needs are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, including management of wound, weights and specialised nursing care needs.

**Standard 4 Requirement (3)(e)**

* Ensure staff have the skills and knowledge to:
	+ identify referral needs in response to changes in consumers’ emotional and psychological well-being care needs and preferences.
* Ensure management and staff are aware referral opportunities for consumers to individuals, other organisations and providers of other care in relation to services and supports for daily living.
* Ensure policies and procedures in relation referrals in line with Requirement (3)(e) in Standard 4 are effectively communicated and understood by staff.

**Standard 7 Requirement (3)(c)**

* Ensure staff have the skills and knowledge to:
	+ review and evaluate the effectiveness of consumers’ care and services.
	+ complete wound documentation in line with the service’s expectations.
	+ evaluate and review consumers’ management strategies and changes in consumers’ health and well-being, including weight loss.
	+ Implement actions in line with Medical officer directives, including in response to blood glucose levels out of range.

**Standard 8 Requirements (3)(c) and (3)(e)**

* Ensure management and staff are aware of legislative responsibilities in relation to compulsory reporting.
* Implement processes to collate and analyse clinical incident data, including antibiotic use, to assist with identifying trends and improvement opportunities.
* Implement processes to monitor use of psychotropic medications and assist in identifying opportunities to reduce psychotropic medication use.
* Implement monitoring processes to ensure appropriate use of the new electronic care system.