Glenrose Court

Performance Report

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**Commission ID:** 6764

**Provider name:** Churches of Christ Life Care Incorporated

**Assessment Contact - Site date:** 30 November 2020

**Date of Performance Report:** 15 February 2021

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(f) | Compliant |
| **Standard 8 Organisational governance** | **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, staff and others
* the provider’s response to the Assessment Contact - Site report received 21 December 2020.

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Assessment Team assessed Requirement (3)(b) in Standard 3 as part of the Assessment Contact and have recommended this Requirement as met. All other Requirements were not assessed and, therefore, an overall rating of the Standard is not provided.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 3 Requirement (3)(b) and find the service Compliant with this Requirement.

The service demonstrated effective management of high impact or high prevalence risks associated with the care of consumers. The service has a comprehensive and imbedded system to identify, record, investigate and action clinical incidents. Clinical assessment and planning processes assist to identify consumer risks on entry and on an ongoing basis, including when incidents and changes to consumers’ health and well-being occur and during regular reviews.

Information gathered through assessments, specialist reviews and monitoring is used to develop comprehensive care plans outlining detailed strategies to inform staff of the management of consumers’ personal and clinical care, including any associated risks.

Consumer files viewed by the Assessment Team demonstrated risks associated with falls, weight loss and challenging behaviours are identified and monitored, and strategies documented are applied by staff to effectively manage the risks. All staff interviewed were able to provide examples of risks associated with individual consumers and management strategies implemented in line with consumers’ care plans. All consumers interviewed were satisfied with how clinical care was managed by staff, including when they were unwell or following an incident.

The Assessment Team did identify some deficits in clinical documentation relating to wound management and pain. However, consumers interviewed, and progress notes and care plans viewed demonstrated wounds are managed effectively through appropriate wound dressings and treatment and staff identify and take appropriate action to manage consumers who report or show signs of pain.

Based on the information detailed above, I find the provider, in relation to Glenrose Court, does comply with Requirement (3)(b) in Standard 3.

## Assessment of Standard 3 Requirements

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

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

# STANDARD 4 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 Requirement (3)(f) in Standard 4 as part of the Assessment Contact and have recommended this Requirement as met. All other Requirements were not assessed and, therefore, an overall rating of the Standard is not provided.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 4 Requirement (3)(f) and find the service Compliant with this Requirement.

Overall, sampled consumers considered that they are provided meals suitable to their individual preferences. The following examples were provided by consumers during interviews with the Assessment Team:

* like the food, are offered choices, the food is nice, and the dining experience is lovely.
* meals here in the home “are like my wife’s, lovely”.
* if they want, they can provide feedback about the meals to staff, or they can tell family.

Consumer dietary preferences are identified through consultation and assessment processes. Dietary summary reports are generated weekly and as changes to consumers’ dietary needs occur. Reports include each consumer’s diet type, food and fluid likes and dislikes, consistency and food allergies and intolerances. Dietary information is available to staff, including hospitality staff. Consumers were observed by the Assessment Team to be provided with meals and drinks in line with their documented dietary preferences. Staff described individual strategies for consumers who receive modified diets in line with the Dietary summary report and stated they are notified of any changes to consumers’ dietary care needs.

The service has a seasonal menu which includes a range of choices. Consumers are able to provide feedback in relation to the menu through a range of mechanisms, including meeting forums. Feedback provided by consumers is taken into consideration and incorporated into the menu.

Based on the information detailed above, I find the provider, in relation to Glenrose Court, does comply with Requirement (3)(f) in Standard 4.

## Assessment of Standard 4 Requirements

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

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

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

The Assessment Team assessed Requirement (3)(e) in Standard 8 as part of the Assessment Contact and have recommended this Requirement as not met. All other Requirements in this Standard were not assessed.

The service has a clinical governance framework, including in relation to antimicrobial stewardship, open disclosure and minimisation of restraint. However, the Assessment Team were not satisfied the service demonstrated effective systems in relation to minimisation of restraint to ensure psychotropic medications were appropriately reviewed and monitored or that appropriate consultation occurred with consumers and/or their representatives in relation to the use of the medications.

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

## Assessment of Standard 8 Requirements

### 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 service demonstrated effective systems in relation to minimisation of restraint to ensure psychotropic medications are appropriately reviewed and monitored and that appropriate consultation occurred with consumers and/or their representatives. This was evidenced by the following:

* Management stated there are no chemical restraints in use at the service.
* A report provided indicated 67% of consumers are currently prescribed a psychotropic medication. Management stated consumers prescribed a psychotropic medication have the medications used for treatment of a diagnosed medical condition and, therefore, the use of the medications is not considered a form of chemical restraint.
* As the service does not consider the medications a form of chemical restraint, actions, such as assessment, monitoring, evidence of trialling alternatives or written and recorded consultation and informed consent from the consumer and/or representative are not initiated in line with the organisation’s restraint procedure.
* Five consumer files viewed confirmed there is no documented evidence of consultation, consent or alternatives trialled prior to commencing and using the psychotropic medication.
* Two consumer files viewed indicated consultation had not occurred with the consumer and/or representative when a consumer is commenced on a psychotropic medication to ensure informed consent occurs.
* Management acknowledged deficits in the recording and documentation of psychotropic medication, including no documented evidence of discussion with the consumer and/or representative.
* Management stated it is the Medical officer’s responsibility as the prescriber to consult and discuss the medications with the consumer.
* Current prescribed psychotropic medications are monitored through maintaining a spreadsheet. Areas of the spreadsheet, including alternatives used, restraint reviewed, frequency of monitoring and representative consulted were not completed.
* Consumers are recorded on the spreadsheet as prescribed psychotropic medications which are not considered chemical restraint by the service as they are recorded as being given for the treatment of dementia. The medications prescribed are not recognised as medications used for the treatment of dementia.

The provider’s response acknowledged there were gaps in documentation and in the accurate interpretation of chemical restraint, however, did not agree with the Assessment Team’s recommendation. The response included a Continuous improvement plan directly addressing the issues identified in the Assessment Team’s report as well as supporting documentation, demonstrating the service has been proactive in addressing the issues identified. The provider’s response indicates:

* All consumers currently administered/prescribed psychotropic medications have been reviewed, including diagnosis to support use.
* Supporting documentation provided demonstrated medications for a sample of consumers have been reviewed by senior clinical staff, Medical officers have ceased medications identified as not being required and/or reduced the dose of medication prescribed and discussions relating to risks associated with the medications have been undertaken with representatives.
* Letters have been sent to Medical officers following review of consumers’ psychotropic medications requesting reasons for prescribing psychotropic medication, a related diagnosis and reinforcing need for consultation with consumer or representative.
* Consultation relating to use of psychotropic medication has been added to the four monthly consumer care evaluation process.
* Clarified the use of dementia as a diagnosis for use of psychotropic medications.
* Email sent to all clinical staff requesting accurate documentation of strategies initiated prior to administration of ‘as required’ psychotropic medication.

I acknowledge the provider’s response, the supporting documentation provided, and actions initiated in response to the Assessment Team’s findings. However, in coming to my finding, I find at the time of the Assessment Contact, the organisation’s systems for reporting and monitoring psychotropic medication use were not effective. I have considered management’s stance indicating consumers prescribed psychotropic medications have the medications used for treatment of a diagnosed medical condition and, therefore, these medications are not considered chemical restraint. As such, assessment, monitoring and evidence of trialling alternatives are not initiated or recorded. Additionally, consultation and informed consent from the consumer and/or representative is not written and recorded, including prior to administration of psychotropic medications. I find that the evidence provided in the Assessment Team’s report demonstrates the service is not complying with their responsibilities under the *Quality of Care Principles 2014 Part 4A - Physical or chemical restraint to be used only as a last resort*, *section 15G*.

I have also considered information in the Assessment Team’s report indicating psychotropic medications, not recognised as medications for the treatment of dementia are recorded as such and are not considered by the service as chemical restraint.

Based on the information detailed above, I find the provider, in relation to Glenrose Court, does not comply 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.

The service has developed a Continuous improvement plan directly addressing issues identified by the Assessment Team in the relevant Requirements and have included actions and progress.

**In relation to Standard 8 Requirement (3)(e):**

* Ensure staff have the skills and knowledge to:
* identify where psychotropic medications administered to consumers constitute chemical restraint.
* implement appropriate assessment, initiate monitoring processes and document evidence of trialling alternatives where chemical restraint is used.
* consult with the consumer and/or representative in relation to risks of psychotropic medications being administered.
* Ensure processes in relation to use of chemical restraints are in line with the provider’s responsibilities as outlined in the *Quality of Care Principles 2014*.
* Ensure policies, procedures, guidelines and relevant legislation in relation to chemical restraint are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, guidelines and relevant legislation in relation to chemical restraint.

**Other relevant matters**

The provider’s response indicates the service did not provide the Assessment Team with information regarding consumers who were not Commonwealth funded at the time of the Assessment Contact. The provider notes two state funded consumers are reflected in the Assessment Team’s report. In coming to my findings of compliance for the Requirements assessed, information provided in the Assessment Team’s report in relation to these consumers has not been considered.