Ira Parker Nursing Home

Performance Report

16 War Memorial Drive
BALAKLAVA SA 5461
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**Commission ID:** 6004

**Provider name:** Yorke and Northern Local Health Network Incorporated

**Assessment Contact - Site date:** 20 January 2022

**Date of Performance Report:** 1 March 2022

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will 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 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

This performance report details the Commissioner’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 following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers and representatives
* the provider’s response to the Assessment Contact - Site report received on 7 February 2022, noting the provider accepted the findings and outcomes of the report without further comment
* the Performance Report dated 18 May 2021 for the Site Audit undertaken 10 March 2021 to 15 March 2021.

# 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) only in this Standard as part of the Assessment Contact. Accordingly, an overall rating of the Standard has not been provided.

Requirement (3)(b) in Standard 3 was found Non-compliant following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team’s report included evidence of actions taken to address deficiencies identified at the Site Audit and the Assessment Team have recommended Requirement (3)(b) met.

I have considered the Assessment Team’s findings and evidence documented in the Assessment Contact - Site report and based on this information, I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, to be Compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care. I have provided reasons for my finding below.

### Assessment of Standard 3 Requirements

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

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

The service was found Non-Compliant with Requirement (3)(b) following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found risks associated with consumers’ care delivery were not effectively managed, including risks associated with weight loss management, wound care delivery, blood pressure monitoring and administration of medication.

At the Assessment Contact in January 2022, the Assessment Team found the service had implemented improvements to address the identified deficiencies, including, but not limited to:

* implementing a work instruction which clarifies weight monitoring documentation requirements, including capturing reasons for weighing and detailing variance from previous results, and commencing use of a weight capture spreadsheet tool;
* review of the referral process to Allied health professionals, in addition to instigating an audit tool to ensure any subsequent follow up is completed;
* providing additional training for staff in both wound care and reporting observations;
* modifications to the service’s electronic documentation system to allow better tracking of wound progress, and heightened staff awareness of wounds through monthly reporting and staff meetings;
* undertaking documentation audits to ensure staff are escalating reportable observations to the Medical officer where applicable and managing staff performance where this does not occur; and
* installation of a DDA cupboard in the Ira Parker nursing station to improve ease of access to schedule 8 and schedule 4 medications, in addition to design and implementation of work instructions to support better medication management.

The Assessment Team presented the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Documentation reviewed showed Allied health review was sought in relation to swallowing and choking risk for one consumer; recommendations to mitigate risk were included in care planning documentation and no subsequent incidents have occurred.
* Documentation reviewed for one consumer at high risk of falls showed staff had identified when the consumer’s blood pressure was recorded outside of normal range, however, staff did not complete follow up actions. The service demonstrated it had identified this deficiency through an audit, undertook an investigation and took appropriate action.
* The service has a risk report which monitors a broad spectrum of high impact or high prevalence risks and have identified specific risks to individual consumers. Monthly reporting shows what actions have been implemented to reduce incidents.
* Staff demonstrated they were familiar with the service’s incident reporting protocol and practices, including those relating to high risk incidents.

In coming to my finding, I have considered that the service has implemented monitoring processes and mitigation strategies to manage high impact or high prevalence risk to consumers, including through work instructions and staff training, and staff demonstrated they recognise risks relating to individual consumers.

For the reasons detailed above I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, Compliant with Standard 3 Requirement (3)(b).

# STANDARD 7 Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) only in this Standard at this Assessment Contact. Accordingly, an overall rating of the Standard has not been provided.

Requirement (3)(a) in Standard 7 was found Non-compliant following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found the service was unable to demonstrate the workforce was planned to enable delivery and management of safe and quality care and services.

The Assessment Team’s report included evidence of actions taken to address deficiencies identified at the Site Audit and the Assessment Team have recommended Requirement (3)(a) met.

I have considered the Assessment Team’s findings and evidence documented in the Assessment Contact - Site report and based on this information, I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, to be Compliant with Requirement (3)(a) in Standard 7 Human resources. I have provided reasons for my finding below.

**Assessment of Standard 7 Requirements**

**Requirement 7(3)(a) Compliant**

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

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found the service did not demonstrate that the number and mix of the workforce deployed enabled the delivery and management of safe and quality care and services. The findings specifically related to staff ability to provide adequate care for consumers when emergency presentations occurred in the accident and emergency area of the service’s co-located hospital.

At the Assessment Contact in January 2022, the Assessment Team found the service had implemented improvements to address the identified deficiencies, including:

* implementing a new roster which identifies clinical staff allocation between the service and co-located hospital;
* undertaken recruitment activities for additional clinical staff; and
* implementing an ‘on call’ system and associated roster guidance for staff.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Feedback from consumers and representatives sampled during the Assessment Contact who felt there was adequate numbers of staff to meet consumers’ care needs, including answering call bells promptly.
* Feedback from staff who felt there were sufficient staff, and management support, to facilitate delivery of quality care and services.
* Documentation viewed, including the feedback and complaints register, call bell data and staff allocation sheets, did not raise concern regarding staff availability to provide timely care and services to consumers.

In coming to my finding, I have considered that the service has demonstrated a review of staffing with subsequent implemented changes to deliver safe and quality care and services.

For the reasons detailed above I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, Compliant with Standard 7 Requirement (3)(a).

# STANDARD 8 Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Assessment Team assessed Requirement (3)(d) only in this Standard at this Assessment Contact. Accordingly, an overall rating of the Standard has not been provided.

Requirement (3)(d) in Standard 8 was found Non-compliant following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found the service was unable to demonstrate effective oversight and management of high impact and high prevalence risks associated with consumers.

The Assessment Team’s report included evidence of actions taken to address deficiencies identified at the Site Audit and the Assessment Team have recommended Requirement (3)(d) met.

I have considered the Assessment Team’s findings and evidence documented in the Assessment Contact - Site report and based on this information, I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, to be Compliant with Requirement (3)(d) in Standard 8 Organisational governance. I have provided reasons for my finding below.

**Assessment of Standard 8 Requirements**

**Requirement 8(3)(d) Compliant**

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

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 10 March 2021 to 15 March 2021 where it was found the service did not demonstrate effective oversight and management of high impact and high prevalence risks associated with consumers.

At the Assessment Contact in January 2022, the Assessment Team found the service had implemented improvements to address the identified deficiencies, including:

* Commencing use of a risk assessment tool with associated reports being discussed at regular clinical risk meetings.
* Treating incorrect or missed post-falls observations as a reportable incident under the Serious Incident Response Scheme and undertaking performance management of staff.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service has an incident reporting system and staff could describe the reporting process.
* The service’s care evaluation process, risk meetings and electronic risk management system serve as a risk monitoring system, however, audits or reviews are conducted when required. For example, in the evidence provided under Standard 3 Requirement (3)(b), the Assessment Team noted the service identified a deficiency with post-fall blood pressure monitoring through an audit process, and undertook follow up actions.
* Monthly reporting captures consumer incidents; actions taken to reduce incidents, and outcomes for consumers once mitigation strategies are applied.
* Staff receive annual incident management training, and both staff and board members have received training relating to the Serious Incident Response Scheme.
* The service has a policy which outlines how staff can supporting consumers to take risks.

In coming to my finding, I have considered that the service has reviewed their risk management systems and processes to enable improved oversight of risk and to inform delivery of care and services.

For the reasons detailed above I find Yorke and Northern Local Health Network Incorporated, in relation to Ira Parker Nursing Home, Compliant with Standard 8 Requirement (3)(d).

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.