Kirkbrae Kilsyth Hostel

Performance Report

794 Mt Dandenong Road
KILSYTH VIC 3137
Phone number: 03 9724 5200

**Commission ID:** 3156

**Provider name:** Presbyterian Church of Victoria Trusts Corporation

**Assessment Contact - Site date:** 21 October 2020

**Date of Performance Report:** 18 November 2020

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received 12 November 2020
* the Notice of Requirement to Agree to Certain Matters and Consideration of Sanctions dated 29 July 2020.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team assessed three of the requirements in Standard 2. All other Requirements in this Standard were not assessed and therefore an overall rating for the Quality Standard is not provided.

## 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.*

A COVID-19 outbreak occurred at the service in July 2020. As a result of consumers being exposed to serious consequences, including an immediate and severe risk that care recipients may suffer serious harm, the management of the service was taken over by an external health organisation. The provider was returned clinical management of the service on l3 October 2020 and has full oversight of clinical assessment and planning with the support of an independent clinical nurse advisor.

The Assessment Team found that assessment and planning for those consumers sampled, included assessment of risk(s) to the consumers’ health and well-being and strategies to deliver safe care were evident. Assessments were evaluated for currency across consumers who remained at the service and some who were transferred to hospital during the COVID-19 outbreak and subsequently returned to the service. Care domains reviewed included relevant assessments and consideration of risk in falls, skin integrity and weight loss. Strategies included a re-admission checklist, oversight by a registered nurse and a care plan evaluation by a care manager.

The Assessment Team found improved oversight of clinical care assessment and care planning to be at a level which addressed the deficits identified during the COVID-19 outbreak.

Based on the evidence summarised above the service complies with this requirement.

### 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.*

The Assessment Team found that assessment and planning is generally completed with the involvement of the consumer and/or their representative and other organisations or individuals based on the preferences of the consumer. An evaluation of care is conducted in partnership with the consumer on a three-monthly cycle or more frequently as required. Care planning involves relevant third parties such as dietitians, physiotherapists, medical practitioners and geriatricians.

Representatives of consumers noted some barriers and times of poor communication during the COVID-19 outbreak, however, the service has been open to further conversations/meetings to discuss ongoing care needs.

Based on the evidence summarised above the service complies with this requirement.

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team reviewed care plans for the regularity and effectiveness of clinical reviews and found these satisfactory. The service records incidents such as falls, changes in skin integrity and behavioural incidents in an electronic care planning system. There are processes to follow up incidents/changes identified.

Deficits in the management of incidents during the COVID-19 outbreak have been addressed.

Based on the evidence summarised above the service complies with this requirement.

# 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 three specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found while the service has recommenced their psychotropic medication project to support a best practice approach, medical practitioners have not yet signed authority documentation.

Further deficits include gaps in information in relation to reason(s) why a consumer is prescribed a medication, which the Assessment Team found to be generic. Records to identify current behaviours, trigger(s) and strategies had either no information or information that was not tailored to the consumer’s current behavioural challenges.

The Assessment Team considered pain as a contributing factor to behaviours and found pain charting is not consistently completed to identify a consumer’s pain

The provider’s response notes general practitioners have been limited in their ability to visit the service due to COVID-19 and note that while some doctors are yet to sign the form, this in itself does not indicate a lack of consent, as the appropriate consent has been obtained by nursing staff and follow up with general practitioners of the consent process is occurring as a priority.

The provider acknowledges an opportunity to personalise the information on the psychotropic medication register to bring more clarity as to the reason for the use of the medication.

The provider notes while consumers were under the care of the external health provider the electronical pain records may not have been fully completed, however all consumers remained pain free. Staff have been reminded of their duty to complete pain charting for the presence or absence of pain so that strategies to support consumers remain as pain free as possible are developed and implemented.

Based on the evidence above the service does not comply with this requirement as improvements to support the management of psychotropic medication and practices to support consumers to be as pain free as possible are not fully realised.

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

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

The organisation has identified potential high impact and/or high prevalence clinical risks for their consumers (post COVID-19 outbreak) are weight, falls and pressure injuries. The Assessment Team found a full analysis of consumers’ weights has been completed and where required, appropriate actions implemented. Instances of consumers’ falls have also been appropriately followed up and actioned.

The deficits which were evident during the organisation’s failure to manage the risks associated with poor outcomes for consumers during the COVID outbreak have been mitigated.

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

*Minimisation of infection related risks through implementing:*

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

On 20 July 2020 the provider was found to have failed to implement appropriate and timely infection control at the service following notification of the first positive COVID-19 infection. At this time the provider failed to demonstrate that appropriate processes and systems to reduce and manage the risk of further infection at the service were in place.

The Assessment Team’s observations on the day of this visit 21 October 2020 noted a number of areas for improvement. On the day of the assessment, personal protective equipment supplies had not been replenished and were not available at a ‘donning and doffing’ station. The Assessment Team also observed more than one staff member touching their face mask and not performing hand hygiene before moving onto other tasks. An infection control monitoring visit in September 2020 noted similar staff practice.

The provider’s response notes ongoing supervision of staff use of personal protective equipment and ample personal protective equipment being available at the service.

Based on the evidence above the provider does not comply with this requirement as the use of personal protective equipment does not fully support an infection minimisation approach.

# 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 two specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

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

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

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

The Assessment Team found while the service demonstrated they have identified some high impact or high prevalence risks for their consumers such as unplanned weight loss and falls due to deconditioning. The service did not adequately demonstrate oversight of precautions to prevent and control infections such as COVID-19 or oversight of the management of psychotropic medications.

The provider’s response outlines there have been no systemic changes to infection control processes incorporated by the external health organisation since the handover back to Kirkbrae’s management team, however, acknowledges that at times there may be shortfalls in individual staff practices.

Based on the evidence summarised above the service does not comply with this requirement as while management are monitoring staff practices, the monitoring is not resulting in changes to staff behaviour.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The Assessment Team found the organisation is in a period of review post COVID-19 outbreak and is yet to establish their clinical governance team.

The provider’s response specifies that a Social Services Committee has been the governing body for Kirkbrae since its inception, however, the Presbyterian Church Victoria is in the process of implementing revised governance arrangements and the appointment of an experienced Board of Directors is being finalised.

A Clinical Governance Sub-Committee has been in place for over 12 months and met monthly prior to the outbreak.

As part of the transition to the Presbyterian Church Victoria, management are implementing a comprehensive Risk Management and Clinical Governance Framework to further guide the work of both management and the Clinical Governance Committee.

Considerable progress has been made in relation to the senior management team and recruitment to key positions including clinical lead positions.

Based on the evidence above, governance including clinical governance is not fully established and/or will be reviewed. At the time of the assessment contact the service did not comply with Requirement 8(3)(e).

# 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.

* Finalise a best practice approach to the management of psychotropic medications.
* Investigate any barriers to staff not adhering to effective infection control minimisation practices and strengthen oversight / competency of the use of personal protective equipment.
* Finalise how the governing body / clinical governance team provides leadership to staff and has oversight of clinical practices, care delivery and clinical outcomes for consumers.