Montana Aged Care Facility

Performance Report

36 Harbour Street
MOSMAN NSW 2088
Phone number: 02 8969 2600

**Commission ID:** 0555

**Provider name:** Montana Nursing Home Pty Ltd

**Assessment Contact - Site date:** 1 September 2020

**Date of Performance Report:** 1 October 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

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| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(g) | Non-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 staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received 24 September 2020.

# 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

There is insufficient minimisation of infection related risk. There is a lack of outbreak preparedness.

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

### Assessment of Standard 3 Requirements

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found that there is insufficient minimisation of infection related risk. There is a lack of outbreak preparedness. The living environment does not support infection control management and risk minimisation. The Assessment Team found staff and management were unable to demonstrate sound understanding of their individual responsibilities in relation to minimisation of risks in preventing and controlling infections at the service. The Assessment Team provided information of inconsistencies identified during the Quality Commission’s Service Risk Assessment: Covid-19 checklist, for example:

* Outbreak Management Plan
* Personal Protective Equipment
* Infection Control Measures
* Workforce
* Communications and Signage

The approved provider provided a response that included correcting some information in the report, evidence of corrective actions that have occurred since the assessment contact, including education provided, with reviewed and updated processes. While the response included evidence such as care plans, charting, progress notes, and photographs; I noted that the attached documents did not include some evidence the response detailed was included. I note that while the approved provider has acknowledged some aspects the Assessment Team found, the approved provider refutes a majority of the Assessment Team’s findings.

I have considered and accept evidence supplied by the approved provider that shows the provider has ‘coordinated with the plans of other organisations in their communities and local/regional pandemic plans’ as stated in the CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia; by coordinating their outbreak plan with their local Northern Sydney Local Health District. However, guidelines designed specifically in response to minimisation of infection related risks for standard and transmission-based precautions have been expanded, specifically in relation to covid-19.

I have considered the Assessment Teams report and the Approved Providers response. I note some improvement activities have occurred after the audit, and the Approved Provider has acknowledged some of the findings of the service at the time of the audit. It is appropriate to review and consolidate these improvements over a period of time, to consider if they have been effective and sustainable.

I find this requirement is non-compliant.

# 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

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Deficits were found in governance of clinical care.

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

## 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 found that the service did not have a clinical governance framework, including antimicrobial stewardship, minimising the use of restraint, and open disclosure. The Assessment Team identified that clinical governance at the service did not identify and analyse trends in clinical indicators and disseminate this information through the clinical team to correct and minimise any issues identified. The Assessment Team also identified recent changes in the clinical leadership at the service and the redefining of their roles.

The approved provider provided a response that included correcting some information in the report, evidence of corrective actions that have occurred since the assessment contact, including education provided, reviewed and updated processes. I note that while the approved provider has acknowledged some aspects the Assessment Team found, the approved provider refutes a majority of the Assessment Team’s findings.

I have considered and accept evidence supplied by the approved provider that shows the management team is aware and understands their responsibilities related to clinical governance, antimicrobial stewardship, minimising use of restraint, and open disclosure; however, on balance of evidence, I am not convinced this knowledge has been developed and evident throughout the clinical team. The response identifies the recent changes that have occurred within the service, and the impact of that, and the pandemic has had on the service.

I have considered the Assessment Teams report and the Approved Providers response. I note some improvement activities have occurred after the audit, and the Approved Provider has acknowledged some of the findings of the service at the time of the audit. It is appropriate to review and consolidate these improvements over a period of time, to consider if they have been effective and sustainable.

I find this requirement is non-compliant.

# 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.

* Management and staff understand and are trained in best practice guidelines for infection control, including preparing for outbreaks involving covid-19 and the preparing of an outbreak management plan in accordance with CDNA guidelines.
* Management and staff are able to implement and demonstrate best practice in clinical governance, including, but not limited to minimising restraint, and open disclosure.
* Management and staff understand their responsibilities in compulsory reporting, including the maintaining of a consolidated register that contains all incidents of suspected or alleged assaults, and wandering behaviours; and the justification for not contacting the commission or police if not required.
* Improvements that are implemented are monitored and reviewed for effectiveness, and audits and senior staff checks are updated to reflect changes.