Olive Grove Aged Care

Performance Report

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**Commission ID:** 6857

**Provider name:** Willshire Pty Ltd

**Assessment Contact - Site date:** 22 June 2021

**Date of Performance Report:** 23 July 2021

# 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

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(e) | Compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(e) | 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 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, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 12 July 2021
* the Performance Report dated 9 March 2021 for the Site Audit conducted 2 November 2020 to 4 November 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 Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess Requirement (3)(e) in Standard 2. This Requirement was found Non-compliant following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found for two consumers, indications of non-verbal signs of pain were not always been captured on pain assessments to assist in effective review of the efficacy of current pain management interventions or assist in identifying activities which induce or exacerbate pain. The service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below.

The Assessment Team have recommended Requirement (3)(e) met. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 2 Requirement (3)(e) and find the service Compliant with Requirement (3)(e). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 2 Requirements

### 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 service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found for two consumers, indications of non-verbal signs of pain were not always captured on pain assessments to assist in effective review of the efficacy of current pain management interventions or assist in identifying activities which induce or exacerbate pain. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the pain management policy with minor word changes made for clarity of responsibilities and accountability, including in relation to pain assessment processes.
* Developed a Pain flowchart which outlines the pain procedure and documentation requirements.
* Developed a flowchart for documenting pre and post assessment of a consumer when administering as required analgesia.
* A report is generated monthly to ensure administration and evaluation of as required analgesia is captured in pre and post pain charting. Follow up education is provided to individual staff members where deficits are identified.
* Education sessions conducted with staff in relation to pain management, use of pain flow charts and assessing pain pre and post interventions.

Information provided to the Assessment Team by consumers, representatives and staff through interviews and documentation sampled demonstrated:

Most consumers and representatives considered consumers receive the personal and clinical care they need. Representatives confirmed they are notified of changes in care delivery and when incidents occur and indicated they had been involved in care plan reviews. Three of four consumers reported their pain is well managed and one consumer confirmed they had been assessed by nursing and allied health staff following a fall and additional measures had been initiated.

Three consumers were not satisfied with elements of care relating to nutrition/oral and dental, continence and skin integrity. The provider’s response, and information included in the Assessment Team’s report indicates the consumers’ care needs in relation to these areas had been identified and management strategies documented. In response to the consumers’ feedback, the provider indicates a number of actions have been initiated for these consumers following the Assessment Contact, including further consultation, monitoring processes and reviews by Medical officers and/or allied health specialist.

Consumer files sampled demonstrated review of care and services occurs on a regular basis and when circumstances change, or incidents occur. Documentation demonstrated monthly care plan reviews occur in consultation consumers and/or their representatives. Where changes to consumers’ health had been identified or incidents had occurred, further monitoring processes had been implemented, management strategies reviewed and/or developed, Medical officer and/or allied health reviews initiated and care plans updated.

Staff confirmed care and services are reviewed on a monthly basis and demonstrated knowledge of organisational processes for reviewing consumers’ care and services following incidents or changes to circumstances. Clinical and care staff described incident management processes and confirmed they had received training, including in relation to pain management processes.

For the reasons detailed above, I find Willshire Pty Ltd, in relation to Olive Grove Aged Care, Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 5 Organisation’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 Assessment Team assessed Requirement (3)(b) in Standard 5 Organisation’s service environment as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess Requirement (3)(b) in Standard 5. This Requirement was found Non-compliant following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found consumers were unable to freely access outside areas. The service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirement below.

The Assessment Team have recommended Requirement (3)(b) met. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 5 Requirement (3)(b) and find the service Compliant with Requirement (3)(b). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 5 Requirements

### 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.*

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found where it was found consumers were unable to freely access outside areas. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Installed new keypads to allow auto release function for some doors.
* Procedures for locking and unlocking of doors with no keypads were observed in the nurse base and medication room.
* Staff messages sent to remind staff to unlock all doors between the required hours.

Information provided to the Assessment Team by consumers and staff through interviews, observations and documentation sampled demonstrated:

Consumers confirmed they are able to access indoor and outdoor areas and stated doors to outdoor areas are always unlocked. One consumer stated they recently had an incident with a handrail in the bathroom. The Assessment Team’s report and the provider’s response indicates that whilst the incident was not reported at the time, once maintenance were alerted, the issue was rectified promptly.

The service environment was observed to be safe, clean, well maintained and comfortable. Consumers were observed moving freely both indoors and outdoors and doors to external gardens and courtyards were unlocked and open.

Preventative and reactive maintenance and cleaning processes ensure the service environment is clean, safe and well maintained. Staff were familiar with reporting processes for maintenance issues, hazards and incidents. Cleaning staff were observed attending to the service environment and undertaking their duties during the Assessment Contact.

For the reasons detailed above, I find Willshire Pty Ltd, in relation to Olive Grove Aged Care, Compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# 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 Requirements (3)(c) and (3)(e) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess Requirements (3)(c) and (3)(e) in Standard 8. These Requirements were found Non-compliant following a Site Audit conducted 2 November 2020 to 4 November 2020. In relation to Requirement (3)(c), it was found the service did not have effective governance systems in relation to regulatory compliance and open disclosure. In relation to Requirement (3)(e), the service did not demonstrate that the clinical governance framework supported active monitoring, review and implementation of initiatives to reduce inappropriate antibiotic usage and resistance. The service has implemented a range of actions to address the deficiencies identified which are detailed in the specific Requirements below.

The Assessment Team have recommended Requirements (3)(c) and (3)(e) met. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 8 Requirements (3)(c) and (3)(e) and find the service Compliant with Requirements (3)(c) and (3)(e). I have provided reasons for my finding in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) 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 service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found the service did not have effective governance systems in relation to regulatory compliance and open disclosure. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Mandatory education provided to all staff in relation to compulsory reporting, including open disclosure, Serious Incident Response Scheme and the Incident management system, including incident reporting.
* Staff have been notified of updated policies relating to Mandatory reporting, Compliments and compliments and Open disclosure, including through Toolbox meeting forums.
* Developed an Incident management policy.

Information provided to the Assessment Team by staff through interviews, and documentation sampled demonstrated:

The organisation demonstrated effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Policies are currently being reviewed to ensure responsibilities, accountabilities and time frames are clearly outlined to inform staff practice. There are established processes for safe storage and disposal of information and electronic information is password protected with differing levels of access in line with roles and responsibilities.

There are processes to capture, record and action feedback and complaints. Complaints data is monitored to identify trends and identify opportunities for improvement. A Plan for continuous improvement is maintained. Improvements are identified through a range of avenues, including clinical indicators, critical incidents and key performance indicators.

Policies and procedures are updated in response to legislative changes. Recent amendments have been made in response to the Serious Incident Response Scheme requirements and minimising use of restraint. A sample of incident reports viewed demonstrated incidents are reported, incident reports completed, representatives and Medical officers notified and investigations occur.

For the reasons detailed above, I find Willshire Pty Ltd, in relation to Olive Grove Aged Care, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### Requirement 8(3)(e) 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 service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 2 November 2020 to 4 November 2020 where it was found the service did not demonstrate that the clinical governance framework supported active monitoring, review and implementation of initiatives to reduce inappropriate antibiotic usage and resistance. Additionally, in relation to open disclosure, it was found the service did not have a specific open disclosure policy to ensure consistency of staff practices, including practices specifically relating to clinical incidents. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented an Open disclosure policy and mandatory education provided for all staff on Open disclosure. An Open disclosure principles and framework self-directed learning package has also been completed by staff.
* Designed an Open disclosure brochure which was distributed to consumers. The brochure will be included in admission and tour packs.
* Open disclosure has been added to the education schedule to be completed every six months.
* Updated the electronic incident forms to include detailed conversations that are had with consumers and/or representatives.
* The Infection control policy has been embedded and includes information and guidance relating to shared decision making.
* Introduced an antimicrobial tracking database to monitor/track antimicrobial use.
* Antimicrobial use and analysis are reported monthly report at site level and at Clinical governance meetings.
* Clinical staff were reminded at meeting forums and through Toolbox education about monitoring consumers for symptoms of infection and consultation with Medical officers.
* The COVID-19 management plan has been reviewed and updated on as required basis.
* Refresher education provided to staff in relation to the COVID-19 Management plan, including, but not limited to, the location of the plan, the COVID-19 Outbreak management team, cohorting of areas in the event of an outbreak, stock sourcing, signs and symptoms of COVID-19 and identifying and responding to signs and symptoms.
* A personal protective equipment donning and donning practical competency is mandatory for all staff each month.

Information provided to the Assessment Team by consumers and staff through interviews and documentation sampled demonstrated:

The organisation has a clinical governance framework which includes antimicrobial stewardship, minimising use of restraint and open disclosure. These key areas are supported by policies and procedures which are available to guide staff practice.

Clinical staff discussed how they consult with Medical officers and monitor consumer infections, including where antibiotics are prescribed. Care staff confirmed they had received training in relation to infection control and described practices they implement to minimise spread of infection.

A review of consumers prescribed psychotropic medications and the usage of the medication has recently been undertaken. As a result, in consultation with the consumer and/or representative and Medical officer, orders for the medications were ceased for some consumers. Clinical staff described processes implemented to minimise restraint use and were familiar with the organisation’s approach to use of restraint.

A sample of clinical incident reports demonstrated open disclosure processes are implemented. Incident reports included conversations with the consumer and/or their representative. Additionally, a consumer stated they had received an apology following an incident and actions implemented to prevent further occurrence of the incident had been discussed with them.

For the reasons detailed above, I find Willshire Pty Ltd, in relation to Olive Grove Aged Care, Compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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.