Yeltana Nursing Home

Performance Report

25 Newton Street   
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**Commission ID:** 6971

**Provider name:** Whyalla Aged Care Inc

**Assessment Contact - Site date:** 17 June 2020 to 18 June 2020

**Date of Performance Report:** 13 August 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 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(b) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(b) | Compliant |
| **Standard 8 Organisational governance** | **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 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 on 1 July 2020.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as one of the six specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 18 November 2019 to 19 November 2019.

The Assessment Team recommended Requirement (3)(b) in Standard 1 as met. 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 1 and find the service is Compliant with Requirement (3)(b).

At a Site Audit conducted 18 November 2019 to 19 November 2019, in relation to Standard 1, Requirement (3)(b), the Decision Maker found the service’s assessment processes were not effective in identifying or understanding consumers’ cultural preferences or providing staff with strategies to support the provision of culturally safe care. Additionally, staff interviewed were unable to describe culturally safe care in the context of their work environment.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The organisation’s electronic care and clinical management system was updated in May 2020 to create a new consumer lifestyle profile area which relates to cultural and spiritual needs. Consumer files are updated in line with their six-monthly care plan reviews. Staff confirmed the new profile page assists them to provide care and services in line with each consumer’s cultural and religious preferences.
* The organisation’s admission form and checklist have been updated to prompt staff to discuss the cultural needs with new consumers within two days of their admission. Information captured includes religious, spiritual, ethnic and customs requirements, as well as any dietary restrictions or specific cultural practices.
* The organisation has established a database of those staff who identify from various cultural, linguistic and/or religious backgrounds and who said they would be available, as required, to assist consumers of the same or similar background.
* The organisation employs Aboriginal staff who assist in communication with consumers and has developed a tool for all staff on how to communicate with Aboriginal consumers. The staff members are also involved in the admission process for new Aboriginal consumers.
* Staff have completed on-line training on ‘Caring for Indigenous Australians: Aborigines and Torres Strait Islanders’ between January and March 2020 and ‘Cultural Diversity in Ageing’ between August 2019 and February 2020.
* Toolbox and workshop training completed by staff in April 2020 included a Culture and Respect topic.
* The organisation’s training matrix has been updated to include a session on Cultural Diversity in Ageing and staff have been provided with ‘Diversity in Aged Care’ booklets. The matrix also includes mandatory training on ‘Caring for Indigenous Australians’ and ‘Cultural Diversity in Ageing’, to be completed by new staff as part of their orientation process.
* At the staff meeting held on 11 February 2020, cultural awareness was included as the topic of the month.
* The Commission’s Storyboard resources, including how to communicate and provide personal care and services to Indigenous consumers, have been discussed with staff and placed in the staff room for access by staff.
* In relation to Standard 1 Requirement (3)(b), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:
* Consumers said staff understand and are aware of their cultural preferences. One consumer said that while they were born overseas, and they speak English as a second language, they prefer to interact in English and staff are aware of their preference.
* Consumers said staff always ensure their visitors are welcome.
* Management said the service’s assessment processes reflect input from consumers and representatives to establish what they considered culturally safe practices. Management said the service has purchased a number of electronic tablets and has installed a translation application on the tablets.
* Staff said they are provided with information about consumers’ backgrounds and were aware of special requirements and how to make consumers feel safe.
* Staff confirmed they have been provided with training on cultural safety and cultural awareness. Staff said the new profile page provides them with information on each consumer and possible topics when talking to the consumer.
* The organisation has implemented monthly audits to ensure cultural needs are captured in consumers’ care plans. Audit results are tabled at the monthly Residential Senior Management meeting and the Audit, Risk and Clinical Governance Committee meetings.
* Documentation confirmed diverse information is collected about each consumer’s lifestyle story, their daily routines, their cultural and spiritual preferences and their relatives and friends.

For the reasons detailed above, I find the approved provider, in relation to Yeltana Nursing Home, does comply with Requirement (3)(b) of Standard 1.

# STANDARD 2 COMPLIANT 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 Quality Standard is assessed as Compliant as one of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 18 November 2019 to 19 November 2019.

The Assessment Team recommended Requirement (3)(a) in Standard 2 as met. 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 2 and find the service is Compliant with Requirement (3)(a).

At a Site Audit conducted on 18 November 2019 to 19 November 2019, in relation to Standard 2 Requirement (3)(a), the Decision Maker found the service’s assessment processes were not effective in identifying risks to a consumer who chooses to smoke, had not been effectively used for a consumer post a significant choking episode and that respite consumers’ assessment and care planning processes required improvement.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The organisation has reviewed and updated the admission policy to ensure all new consumers, including respite consumers, are assessed within 24 hours and an interim care plan developed. Permanent consumers undergo a full assessment of their needs and an extended care plan developed within six weeks. The policy states that if a consumer has clinical care issues or any risks identified during the initial assessment, the relevant full assessment must be completed, and the interim care plan reviewed.
* A memorandum was sent to staff on 4 December 2019 reminding them of their responsibilities and processes for completing care plans.
* The risk assessment for one consumer who smoked was reviewed in December 2019. The service has implemented improvements for consumers who smoke, including a new ashtray which cannot be tampered with and which is situated near a bench to allow consumers to sit in the shade, and an automatic door installed at reception to enable consumers to easily walk in and out of the service.
* In relation to Standard 2 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:
* Consumers and representatives interviewed confirmed staff listen to them and understand their specific health and well-being requirements.
* Management described the comprehensive assessment and planning processes being undertaken with consumers, including identification of risks and additional assessments by Allied and Health specialists as required. Management said they are monitoring admission assessments and the completion of interim care plans within the prescribed timeframes.
* Clinical staff said care plans are developed in consultation with consumers and representatives. Initial admission assessments include the assessment of risks, such as falls, skin integrity, pain, infections and nutrition. Additional assessments are undertaken as required.
* Documentation confirmed the service has admitted consumers using the new checklist. Documentation also confirmed the care plan review and assessment schedule shows all consumers have current assessments and care plans.
* The organisation monitors compliance with the care planning process through monthly audits. Audit results are tabled at the monthly Residential Senior Management meeting and the Audit, Risk and Clinical Governance Committee meeting.

For the reasons detailed above, I find the approved provider, in relation to Yeltana Nursing Home, does comply with Requirement (3)(a) of Standard 2.

# STANDARD 3 COMPLIANT 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 Quality Standard is assessed as Compliant as one of the seven specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 18 November 2019 to 19 November 2019.

The Assessment Team recommended Requirement (3)(b) in Standard 3 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report, and the approved provider’s response to come to a view of compliance with Standard 3 and find the service is Compliant with Requirement (3)(b).

At a Site Audit conducted on 18 November 2019 to 19 November 2019, in relation to Standard 3 Requirement (3)(b), the Decision Maker found the service was not effectively managing high impact or high prevalence risks associated with the care of each consumer. Wound care assessment and review processes were not being effectively undertaken and chemical restraint had not been assessed to ensure the safety and minimisation of the use of chemical restraint for each consumer.

The service has implemented a range of actions to address the deficiencies identified which I have detailed 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 Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

In relation to physical and chemical restraint:

* The organisation’s restraint policy and procedure have been reviewed and updated in line with restraint minimisation legislative. The restraint policy and procedure provide staff with information and guidance on physical and chemical restraint definitions, and responsibilities in relation to assessments, implementation, documentation, monitoring and review of consumers with restraints.
* The restraint policy provides information and guidance to staff and states that other strategies should be exhausted prior to the use of restraint. The Assessment and Authorisation form should state the strategies trialled, the type of restraint implemented and include how the restraint will be managed and monitored. Restraint measures should be discussed with the consumer and/or representative and details of the conversation recorded on the form.
* For those consumers with ‘as required’ chemical restraint, management has consulted with Medical Officers to reduce the use of chemical restraint.
* The ongoing need for physical restraint is reviewed as per the procedure, care plan or ‘as required’. Chemical restraint is reviewed monthly or as requested by the Medical Officer.
* Training on psychotropic medication has been provided to staff by the Pharmacist in March 2020.
* The organisation’s training matrix has been updated to include mandatory training on restraint which is to be completed by staff as part of their orientation process.
* In relation to wound management:
* The organisation’s wound care assessment and documentation procedure has been reviewed and updated, including a checklist to remind staff to take photographs with a tape measure as a ruler. The reporting of skin issues has been reviewed to provide better data and relevant trending.
* Staff have been provided with information on skin integrity and wound care at clinical and care meetings.
* The Decision Maker notes the Assessment Team identified further improvements in relation to chemical restraint under Standard 8 Requirement (3)(e) which I have considered under this Standard. These improvements are as follows:
* Consumers on psychotropic medications have been reviewed and Medical Officers have been encouraged to cease the medications in line with the legislation. Management said consumers are reviewed three-monthly to continue to encourage minimisation.
* A register of consumers on regular and/or ‘as required’ psychotropic medications has been implemented, is reviewed daily and updated when consumers’ psychotropic medications change.
* Monitoring processes implemented by the organisation include chemical restraint audits to ensure processes are being followed in accordance with the organisation’s restraint policy and procedure, and the legislation.
* The organisation has updated monthly clinical indicators to include physical and chemical restraint.
* Refer to information under Standard 8(3)(e) for further information on physical and chemical restraint.
* In relation to Standard 3 Requirement (3)(b), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:
* Consumers and representatives interviewed confirmed they are provided with safe and effective care. Consumers said they are well looked after, and staff are kind and caring.
* Management described how they manage high impact risks, including perimeter restraint in the memory support unit. Restraint assessments have been completed and the service maintains a consolidated record of assessments and reviews information.
* Management said clinical staff are to complete a wound management competency in June 2020.
* Clinical staff confirmed they are aware of consumers with risk and are provided with information on these consumers at admission, through handover, care plans and progress notes.
* Care staff provided examples of the use of restraint and said that information about consumers at risk is provided to them at handover and through the electronic care files.
* Care staff were provided with information on skin integrity, including pressure area care, and wound care at the staff meeting held on 9 June 2020. This included reminding staff of repositioning, hydration and maintaining skin integrity.
* At a clinical staff meeting on 11 June 2020, clinical indicators and the service’s new wound management processes were discussed, including the Complex wound chart and skin integrity documentation.
* Documentation confirmed wounds are being managed in line with the service’s wound management plans and photographed and measured weekly.
* Diabetic management plans are in place for consumers with a diagnosis of diabetes. Diabetic management plans, blood glucose monitoring records and medications viewed by the Assessment Team confirmed consumers’ diabetes are being managed in line with medical directives and the service’s processes.
* Monitoring of key clinical indicators is undertaken through monthly trending and analysis and discussions at staff meetings.

For the reasons detailed above, I find the approved provider, in relation to Yeltana Nursing Home, does comply with Requirement (3)(b) of Standard 3.

# STANDARD 8 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 Compliant as one of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(e) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 18 November 2019 to 19 November 2019.

The Assessment Team recommended Requirement (3)(e) in Standard 8 as met. 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 8 and find the service is Compliant with Requirement (3)(e).

At a Site Audit conducted on 18 November 2019 to 19 November 2019, in relation to Standard 8 Requirement (3)(e), the Decision Maker found the organisation’s Clinical Governance framework did not lead to the effective implementation of the *Quality of Care Principles 2014* in relation to physical and chemical restraint.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 8 Requirements

### 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 Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Legislative changes are now reviewed by the Executive team and the Audit, Risk and Clinical Governance Committee. If required, changes to organisational policies are endorsed by the Executive team. Management said the organisation’s restraint policy and procedure has been reviewed to reflect legislative requirements.
* In relation to physical and chemical restraint, management said the organisation has implemented a restraint minimisation program, predominantly in relation to chemical restraint, in consultation with medical officers and consumers. Improvements implemented include:
  + emailing the restraint minimisation legislation and information related to the prescription of psychotropic medications to Medical Officers;
  + consumers on psychotropic medications were reviewed and Medical Officers encouraged to cease the medications in line with the legislation. To encourage minimisation, consumers on psychotropic medications will be reviewed three-monthly.
  + a register of consumers on regular and/or ‘as required’ psychotropic medications has been implemented, is reviewed daily and updated when consumers’ psychotropic medications change. The register is monitored by the clinical staff and management monthly and reported to the Executive team;
  + the organisation has identified that consumers in the memory support unit have a perimeter restraint. A perimeter folder has been implemented to collate documentation related to the restraint, including assessments, authorisations and consent forms. Perimeter restraints are monitored and reported to the Executive team.
* Updated information on restraint has been re-sent to consumers and/or representatives.
* Monitoring processes implemented include chemical restraint audits of consumers on psychotropic medications to ensure the organisation’s process is followed. The monthly clinical indictors have been updated to include physical and chemical restraint.
* Clinical indicators are reported to and discussed by the Senior Clinical Care Committee, Executive management team and the Audit, Risk and Clinical Governance Board Committee. Minutes of meetings are provided to the Board.
* In relation to wound management, the reporting of skin issue types has been further broken down to provide better clinical indicator data and to enable relevant trending. Monthly clinical indicators are reported to and discussed by senior and Executive management, and the Board Committee and reported to the Board.
* In relation to Standard 8 Requirement (3)(e), a sample of consumer files viewed, and information provided to the Assessment Team by management and staff through interviews demonstrated:
* The organisation has a Clinical Governance framework, including
  + a quality management system, including the monitoring of monthly clinical indicators and trends, and reporting to the Executive team and Board.
  + an organisational framework relating to antimicrobial stewardship, including infection control policy, anti-microbial resistance procedures, monitoring of infections and antibiotic use, and a training program for staff. Anti-microbial stewardship and infection control is discussed at staff meetings.
  + an organisational framework relating to the minimisation of restraint.
  + an organisational open disclosure policy and framework, including Open Disclosure principles and staff training.
* Documentation confirmed reports from senior management and the minutes of from the Audit, Risk and Clinical Governance Committee meetings include reporting of clinical indicators, incidents of concern, physical and chemical restraint, audit results, feedback and complaints, mandatory reporting and the risk register.
* Staff said they have been provided with training and information on restraint and infection control, including the practical implementation of the policies and training.

For the reasons detailed above, I find the approved provider, in relation to Yeltana Nursing Home, does comply with Requirement (3)(e) of Standard 8.

# 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.