Performance

Report

**1800 951 822**

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| Name: | Adventist Residential Care |
| Commission ID: | 7852 |
| Address: | 31 Webb Street, ROSSMOYNE, Western Australia, 6148 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 26 March 2024 |
| Performance report date: | 12 April 2024 |
| Service included in this assessment: | Provider: 2557 Seventh-Day Adventist Care (Western Australia) Ltd  Service: 4862 Adventist Residential Care |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Adventist Residential Care (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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 Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* an email from the provider dated 8 April 2024 acknowledging the assessment team’s report; and
* a performance report dated 10 October 2023 for an assessment contact undertaken on 16 August 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# 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 required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following an assessment contact undertaken in August 2023 as high impact or high prevalence risks, specifically administration and monitoring of psychotropic medications, were not effectively managed. The assessment team’s report includes a range of actions the service has implemented in response to the non-compliance, including introducing a regular registered nurse forum meeting where high impact or high prevalence clinical risk topics, including appropriate use of restrictive practices are discussed; and undertaking an all staff toolbox training session featuring restrictive practice as the ‘topic of the month’ for January 2024.

At the assessment contact undertaken in March 2024, high impact or high prevalence risks were found to be appropriately identified, assessed and planned for. Care files demonstrate appropriate management of risks relating to falls, weight loss, skin integrity/wound care, and restrictive practices. Care files also evidence involvement of general practitioners and/or allied health professionals in the assessment and management of consumers’ high impact or high prevalence risks. Staff and management are aware of consumers who have risks associated with their care, and strategies to mitigate risk.

Based on the assessment team’s report, I find requirement (3)(b) in Standard 3 Personal care and clinical care compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | 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. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following an assessment contact undertaken in August 2023 as the clinical governance framework was not effective in minimising use of restraint. The assessment team’s report includes a range of actions the service has implemented in response to the non-compliance, including implementing a restrictive practice checklist; undertaking clinical reviews with outcomes documented for reference prior to scheduled restrictive practice reviews by visiting medical staff; and providing staff initial and ongoing education on restrictive practice compliance requirements for visiting medical staff engaged by the service.

At the assessment contact undertaken in March 2024, the organisation was found to have an effective clinical governance framework, including, but not limited to, antimicrobial stewardship, minimising use of restraint and open disclosure. The framework is supported by a range of clinical policies and procedures to guide staff practice and staff receive regular training and education to enhance clinical practice and improve consumer outcomes. Various clinical governance, quality, and compliance meetings are conducted, and reporting mechanisms are used to provide the service and organisation clinical governance and oversight. Clinical audits are undertaken in line with a schedule to assist to identify areas of clinical practice which require improvement.

Policies and procedures relating to infection prevention and control practices, including antimicrobial stewardship are available, and management and staff described their obligations in relation to the safe management and use of antibiotic therapy. Where required, the correct antibiotic is prescribed for the shortest duration of therapy, and is considered in consultation between the general practitioner, clinical staff, consumers, and their representatives, where applicable. Monthly infection reports and related documentation show infection related incidents are reported and regularly reviewed and evaluated.

A restraint register is maintained to assist the organisation to monitor and review consumers prescribed psychotropic medication, including those identified as subject to chemical restraint. Care files for four consumers show psychotropic medication has recently been reviewed by the clinical team in close consultation and authorisation by the general practitioner, with medications either reduced or ceased as a result.

An open disclosure policy is available to guide staff practice and staff are trained in the principles of open disclosure. Management and staff gave examples of where open disclosure has been used, and complaints, incident documentation and care planning documentation confirm the use of open disclosure in response to incidents.

Based on the assessment team’s report, I find requirement (3)(e) in Standard 8 Organisational governance compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)