Performance

Report

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| Name of service: | Aminya Village Hostel |
| Service address: | 14 Adelaide Rd MANNUM SA 5238 |
| Commission ID: | 6136 |
| Approved provider: | Mid Murray Homes for the Aged Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 February 2023 |
| Performance report date: | 23 March 2023 |

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 Aminya Village Hostel (**the service**) has been prepared by M Dubovinsky 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 - 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 Team’s report received 10 March 2023; and
* the Performance report dated 08 August 2022 for the Site Audit undertaken from 31 May 2022 to 03 June 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

The Assessment Team were not satisfied the service was able to demonstrate each consumer is supported to take risks to enable them to live the best life they can. One consumer’s at-risk activity was not effectively reviewed following increased incidents. The following evidence was considered relevant to my finding:

* The consumer had a dignity of risk form completed which outlined a range of strategies to support the consumer’s independence.
* A range of incidents were recorded, including verbal and physical changed behaviours following the development of the dignity of risk form, however, a review of the dignity of risk form was not undertaken.
* Dignity of risk forms were available for other consumers and staff were able to describe individual consumer’s risks and strategies to support consumers in their risk-taking activities.
* The service has a policy and procedure to guide staff and processes to review risk assessments following significant changes to consumers’ mental and or physical health status.

The provider’s response refutes the Assessment Team’s recommendation of not met. The following evidence was provided relevant to my finding:

* Records showing the consumer had a cognitive assessment completed approximately one-month prior to the Assessment Contact which showed the consumer had no cognitive impairment.
* Medical progress notes showing the consumer was reviewed on two occasions prior to the Assessment Contact in relation to their activity and records showing a further medical review undertaken eight days later confirming the medical officer was supportive and aware of the consumer’s choice to undertake the activity.
* An updated right to take risk form with further strategies.
* Record of a conversation six days after the Assessment Contact involving the consumer and management in relation to further informing the consumer of risks associated with undertaking the activity.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view and find the service was able to demonstrate each consumer is supported to take risks to enable them to live the best life they can. In coming to my finding, I have placed weight on the evidence which showed consumers have dignity of risk forms completed and staff were aware of strategies to support consumers in their risk-taking activities. In relation to the specific consumer identified by the Assessment Team, I have noted the medical officer and the service informed the consumer of risks associated with the activity and informed the consumer prior to the Assessment Contact. In addition, I have considered and accepted the evidence in the response which showed the consumer was assessed as having no cognitive impairment prior to the Assessment Contact and used this information to support the consumer in their right to take risks and make an informed decision.

Based on the information summarised above, I find the service Compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | 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. | Compliant |

Findings

Requirement (3)(e) was found Non-compliant following a Site Audit undertaken from 31 May 2022 to 3 June 2022 where it was found the service was unable to demonstrate care and services were regularly reviewed for effectiveness when changes or incidents impacted on the consumer, specifically in relation to changes to consumers’ emotional and psychological well-being. The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Engaged an external clinical consultant to assist in attending to overdue care plan evaluations.
* Implemented weekly reviews of progress notes for high-risk consumers.
* Developed new assessment forms to support the identification of changing consumer care needs.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* Care planning documentation for three consumers showed care and services were reviewed following weight loss.
* One representative said staff identified and addressed changes to their family member’s pain care needs.
* Documentation sampled showed management undertake progress note reviews.
* Staff feedback for one consumer was consistent with the consumer’s needs, goals and preferences.

Based on the information summarised above, I find the service Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Requirements (3)(a) and (3)(b) were found Non-compliant following a Site Audit undertaken from 31 May 2022 to 3 June 2022 where it was found the service was unable to demonstrate;

* consumers get safe and effective clinical care in relation to management of changed behaviours, restrictive practices and falls; and
* effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to management of choking, pressure injuries, wound care and medications.

Requirement (3)(a)

The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Mandatory training provided to relevant staff on post fall management, management of changed behaviours and behaviours support plans.
* Developed documentation in relation to restrictive practices and behaviour support plans.
* Reviewed the admission process to include information on restrictive processes and prompts to ensure relevant consents and authorisations are undertaken.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* Care planning documentation sampled was consistent with the feedback provided by consumers and staff in relation to skin care, emotional support, restrictive practices, pain management and falls management.
* Consumers and representatives sampled were satisfied personal and clinical care was being provided that was safe and right for them.
* Staff sampled were able to describe strategies to manage consumers’ changed behaviours.
* Specialised nursing care plans provided sufficient and relevant information to guide staff. Staff feedback was consistent with the specialised nursing care plans.
* The service has a range of evidence based tools and provides regular training to staff to ensure staff are delivering best practice care.

Based on the information summarised above, I find the service Compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

Requirement (3)(b)

The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Engaged a wound specialist to review all wounds which were chronic or not showing improvement.
* Reviewed documentation in relation to wound management and implemented additional handover processes to ensure wounds are effectively reviewed and evaluated.
* Education provided to staff on wound and medication management, stoma care and management of consumers who are at risk of aspiration.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* Weekly clinical meetings, monthly clinical data evaluations and weekly progress note reviews support the identification and monitoring of consumers’ high impact or high prevalence risks.
* Staff described managing one consumer’s high impact risks associated with aspiration which was consistent with their assessed needs, goals and preferences.
* Documentation showed one consumer’s pressure injury was managed in accordance with their assessment and management plan.
* Two consumers’ files sampled in relation to risks associated with falls showed a range of strategies were developed and appropriate reassessments and reviews were undertaken.

Based on the information summarised above, I find the service Compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Requirement (3)(c) was found Non-compliant following a Site Audit undertaken from 31 May 2022 to 3 June 2022 where it was found the service was unable to demonstrate effective processes in relation to staff knowledge and competency, specifically in relation to the management of wounds, changed behaviours, stoma care and incident reporting. The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* The training calendar has been updated and staff were provided training on a range of topics, including neurological observations, restrictive practices, medication management, wound management, stoma management and incident reporting.
* An additional clinical nurse was employed to allow additional oversight to monitor staff competency.
* A new training platform was implemented and developed to include external modules and allow for effective monitoring for completion.
* A new auditing and schedule is planned to be implemented to further monitor staff competency.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* Five consumers and representatives said both care and clinical staff are competent in their roles.
* Staff sampled said they are supported by management and have the tools and knowledge to effectively perform their roles.
* Progress notes and care planning documentation showed staff are providing effective care and services in relation to personal and clinical care.
* Orientation and recruitment processes ensure staff are recruited with the relevant qualifications and skills and where required additional training is provided to ensure competency.

Based on the information summarised above, I find the service Compliant with Requirement (3)(c) in Standard 7 Human resources.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | 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 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| 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)(d) and (3)(e) were found Non-compliant following a Site Audit undertaken from 31 May 2022 to 3 June 2022 where it was found the service was unable to demonstrate;

* effective risk management systems and practices for the management of high impact or high prevalence risks, reporting and preventing incidents and supporting consumers to live the best life they can. Deficits specifically related to risk management associated with wounds and changed behaviours; and
* effective clinical governance systems in relation to minimising the use of restraint, specifically authorisation, and alternative strategies consistently trialled or documented.

Requirement (3)(d)

The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Staff training on incident reporting, elder abuse, risk management and dignity of risk.
* A committee has been developed to meet bi-monthly and review incidents.
* Risk management policy has been reviewed with further information to guide staff.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* Incident data viewed for the last three months showed incidents are reported appropriately within relevant time frames in relation to the Serious Incident Response Scheme (SIRS).
* Policies and procedures outline risk management processes.
* Processes, such as High-risk meetings ensure consumers’ high impact or high prevalence risks are identified and managed, including changed behaviours.
* Staff confirmed they have access to an incident management system and are informed of incidents through a range of mechanisms.

Based on the information summarised above, I find the service Compliant with Requirement (3)(d) in Standard 8 Organisational governance.

Requirement (3)(e)

The Assessment Team’s report provided evidence of actions taken to address deficits identified, including, but not limited to:

* Policies and procedures in relation to restrictive practices have been reviewed and updated to include the legislative requirements for behaviour support plans.
* Behaviour support plans were reviewed and updated.
* Training on restrictive practices has been added to the annual training module.

The Assessment Team provided the following information collected through interviews and documentation which are relevant to my finding in relation to this Requirement:

* The service has a clinical governance framework and policies and procedures in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure
* Infection data is monitored to identify trends to support antimicrobial stewardship.
* Consumers sampled confirmed open disclosure practices.
* Staff sampled were able to describe restrictive practices in line with legislative requirements for consumers sampled.
* Clinical indicators are monitored and reported on through a range of forums.

Based on the information summarised above, I find the service Compliant with Requirement (3)(e) in Standard 8 Organisational governance.

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