Performance

Report

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| Name: | Bolton Clarke Walkerville |
| Commission ID: | 6908 |
| Address: | 160 - 178 Walkerville Terrace, WALKERVILLE, South Australia, 5081 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 10 October 2024 |
| Performance report date: | 5 November 2024 |
| Service included in this assessment: | Provider: 1599 RSL Care RDNS Limited  Service: 4319 Bolton Clarke Walkerville |

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 Bolton Clarke Walkerville (**the service**) has been prepared by A Kasyan, 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.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# 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 staff, consumers/representatives and others; and
* a performance report dated 29 February 2024 for the assessment contact undertaken 23 January 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not fully assessed |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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 on 23 January 2024, where it was found high impact high prevalence risks associated with the care of each consumer were not effectively managed, specifically in relation to falls, pain, medication management and changed behaviours. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Introduction of weekly falls management and relevant medication audits, and communication of issues discussed in daily staff huddles.
* Education on time sensitive medication management, falls management and clinical deterioration was provided to relevant staff.
* Mandatory medication training for all clinical staff and personal care workers who administer medication.

At the assessment contact conducted on 10 October 2024, the service demonstrated it effectively manages high impact or high prevalence risks associated with the care of each consumer including, behaviour management and the use of psychotropic medication, falls management, skin integrity and wound management, and nutrition and hydration.

Consumers and their representatives were satisfied with the standard of clinical care provided and said they were kept well informed by staff about aspects of their care, and strategies which have been recommended to minimise risks to them. Consumers at high risk of falls, wounds, pain and changed behaviours were found to have assessments completed using validated assessment tools, and strategies recommended to minimise risks are documented in care plans and implemented. Staff were found to be knowledgeable about specific strategies in place relating to each sampled consumer. Where consumers required additional support to minimise risks associated with their care, evidence showed referrals to a medical officer, allied health professionals, and other specialists had been made. Monitoring and review processes are in place to ensure strategies implemented are effective and risks are mitigated.

For the reasons detailed above, I find requirement (3)(b) in Standard 3, Personal care and clinical care, compliant.

# 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 an assessment contact undertaken on 23 January 2024 as the service did not demonstrate staff were competent in medication management, falls management, behaviour management and the use of restrictive practices. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Training sessions were completed for all staff to ensure compliance with mandatory education requirements.
* Improved monitoring of staff compliance with mandatory education requirements and follow up of staff who were overdue for mandatory training.
* Personal development plans were developed for all staff.
* A structured probation review system was established for staff at various intervals to monitor staff progress, and to identify and address any competency gaps.
* Competency trackers were developed to systematically evaluate and document staff competencies.

At the assessment contact undertaken on 10 October 2024, evidence gathered demonstrated systems and processes are in place to ensure the workforce possesses the necessary skills, qualifications, and knowledge to effectively perform their roles. Consumers and representatives expressed their confidence in staff to effectively perform their roles. Staff demonstrated their knowledge and competency in providing care and services in accordance with consumers assessed needs and preferences. Opportunities for improving staff knowledge and competency are identified through the review of clinical indicators, incidents, and feedback mechanisms. Staff are provided training via various methods, and documentation evidenced compliance with mandatory training requirements.

For the reasons detailed above, I find requirement (3)(c) in Standard 7, Human resources, 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)(e) was found non-compliant following an assessment contact undertaken on 23 January 2024, as clinical governance had not identified several consumers as subject to restrictive practice, and chemical restraint was not always used as a last resort. The clinical governance framework, including structures to monitor risks and systems to ensure the safety and quality of care, was not effective. Infection control guidelines were not consistently followed, and consumers with current infections were not handed over to all staff in a timely manner. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Education provided to staff on restrictive practice and person-centred care.
* Implementation of clinical education sessions via a huddle system to improve the delivery of clinical care and services.
* Introduction of a meeting forum with key personnel to ensure appropriate action is taken to address consumers’ care and service needs.

At the assessment contact undertaken on 10 October 2024, an effective clinical governance framework inclusive of antimicrobial stewardship, minimising the use of restraint and open disclosure was demonstrated. The clinical governance framework includes effective reporting and monitoring systems, policies, procedures, and processes. The framework is supported by clinical staff, leadership and oversight at a service and organisation level, including a clinical governance committee, and reporting mechanisms to the board.

Monthly clinical indicators are collected, analysed, and trended including those related to infections and antimicrobial stewardship. Reporting and monitoring processes, and clinical governance meetings ensure clear oversight. Documentation shows staff receive education on antimicrobial stewardship and infection prevention, management, and control. Monitoring the use of psychotropic medications occurs. Policies, procedures and education guide staff in understanding restrictive practices and minimising restrictive practice usage in accordance with relevant legislation and regulatory requirements. The application of open disclosure principles was evident through the review of incident and complaint data, and training records show staff receive education on open disclosure and staff could demonstrate their understanding of open disclosure and its application.

For the reasons detailed above, 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)