Performance

Report

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| Name of service: | Emmavale Gardens |
| Service address: | 7 Elberta Avenue TEMPLESTOWE LOWER VIC 3107 |
| Commission ID: | 3549 |
| Approved provider: | Menarock Aged Care Services (Templestowe) Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 20 December 2022 |
| Performance report date: | 19 January 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 Emmavale Gardens (**the service**) has been prepared by D. Fekonja, 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 - 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.

# Assessment summary

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| Standard 5 Organisation’s service environment | 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 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

During the Site Audit conducted from 1 to 3 June 2022, the service was found non-compliant with requirement 5(3)(b) due to bedrooms being locked when consumers are not in their rooms; this restricted independent and timely access for consumers to their rooms.

At the assessment contact conducted in December 2022, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives confirmed that consumers can move freely and access both indoor and outdoor areas of the service. The service has introduced a process to consult with consumers and/or their representatives in relation to the choice of locked bedroom doors, including the assessment of risk and consent as required. The following processes have been put in place to ensure the safety and well-being of the consumer:

* the service will conduct three-monthly consultations with consumers and representatives to discuss associated risks and obtain consent.
* consumers will be reviewed by allied health for dexterity and ability to use keys to unlock rooms. Spare keys are available for representatives who have requested one.
* signage is placed on consumers’ doors to indicate their preference for their doors to be locked.
* updating the organisation’s restrictive practices policy and toolbox sessions conducted for staff on environmental restraint requirements.
* staff to have keys to consumers’ rooms to assist them when required.

The service has appropriate measures in place for those consumers who choose to lock their bedroom doors. Consumers are able to feel safe in their environment and move freely through the service.

I find the service is now compliant with requirement 5(3)(b).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

During the Site Audit conducted from 1 to 3 June 2022, the service was found non-compliant with requirement 7(3)(a) in that the service did not have the mix and number of staff to ensure the delivery of safe and quality care and services to consumers.

At the assessment contact conducted in December 2022, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The Assessment Team found that the service has made changes to plan the number and mix of staff more effectively to enable safe and quality care and services. The service has recruited new staff to fill vacant shifts in all areas of the service including a new residential manager. The casual bank of staff has been increased to assist with unplanned leave. The service fills unplanned leave in the morning shift with staggered starts and staff from other areas assisting.

Rostering staff advised the Assessment Team that the roster is currently at full capacity. The capacity levels are determined at the organisation level, not the service level, via a master roster. Changes to the master roster can be requested by the residential manager where the need is identified, by sending a request via email to head office.

Rostering staff advised the Assessment Team that the roster is prepared 4 weeks in advance and reviewed daily to fill any unexpected leave as soon as practicable.

The service uses an electronic system that is connected to a phone application which is used by staff to access vacant shifts.

Consumers and their representatives confirmed that staffing levels have improved over recent months. Concerns about the lack of a complete lifestyle program have been addressed with the addition of a lifestyle staff member. One representative has also noticed an improvement in the cleanliness of the service.

The Assessment Team observed care staff responding to call bells promptly and assisting consumers to the dining and activity areas. Call bell response times indicate that over 90% are responded to in under 10 minutes.

I am satisfied the service has in place systems and processes to ensure the workforce is planned to enable, and the number and mix of members of the workforce deployed enables the delivery and management of safe and quality care and services.

I find the service compliant with requirement 7(3)(a).

# 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

During the Site Audit conducted from 1 to 3 June 2022, the service was found non-compliant with requirement 8(3)(e) as it did not identify environmental restraint in the practice of locked doors to consumers’ rooms, thereby limiting independent and timely access for consumers to their rooms

At the assessment contact conducted in December 2022, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service has a clinical governance framework in place that includes oversight of antimicrobial stewardship, minimising the use of restraints, and open disclosure. Management and clinical staff overall were able to discuss how restrictive practices are minimised at the service, documentation requirements, and requirements for consent before using restrictive practices. Chemical restraints are discussed during consultation, and psychotropic medication is reviewed three-monthly, with regular discussions of dosages during medication advisory committee meetings.

The service does not utilise physical restraints and mechanical and environmental restraints are at the request of consumers/representatives. Where beds are placed against walls or requests for doors to rooms to be locked are made, these are documented, assessments conducted and informed consent occurs.

The Assessment Team sighted current policies, attendance to toolbox training for restrictive practice and risks assessments of consumers who requested for their doors to be locked.

The service has the appropriate processes in place to ensure restrictive practices in the form of environmental restraint are identified and effectively managed. Staff have received the necessary training in relation to environmental restraint as it relates to consumers who choose to lock their bedroom doors.

I find the service compliant with requirement 8(3)(e).

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)