Performance

Report

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| Name of service: | Emmerton Park Aged Care Facility |
| Service address: | 2-10 Seniors Drive SMITHTON TAS 7330 |
| Commission ID: | 8006 |
| Approved provider: | Emmerton Park Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 July 2023 to 20 July 2023 |
| Performance report date: | 25 August 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 Emmerton Park Aged Care Facility (the service) has been prepared by N Eastwood, 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.
* the provider’s response to the assessment team’s report received on 22 August 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 3**

* Requirement 3(3)(a) Restrictive practices – psychotropic register and chemical restraint documentation completion
* Requirement 3(3)(b) Falls management – review and audit of post falls management following implementation of neurological observations for unwitnessed falls

**Standard 8**

* Requirement 8(3)(c) Information management and Regulatory compliance – implementation of newly created and updated policies and procedures
* Requirement 8(3)(e) Clinical governance – evaluation of improved staff knowledge related to newly implemented policies and procedures to support staff knowledge of antimicrobial stewardship or restrictive practices

# Standard 2

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

The service was found non-compliant with Requirement 2(3)(a) following a site audit conducted from 23 August 2022 to 25 August 2022. The service at that time did not demonstrate adequate assessment of risk during assessment and planning processes, including risks related to falls, pain, mobility, specialised nursing care and restrictive practice. For new consumers at the service, interim care planning was not always completed to inform safe care. The service’s procedure of completing documentation for new consumers did not prioritise completing risk assessments for known risks or specialised nursing care needs for consumers. The service implemented remedial action in response to the non-compliance identified at the site audit in August 2022 including altering admission processes and documentation and enhancing clinical handover processes.

At this assessment contact, the service demonstrated initial and ongoing assessment and planning for care and services in partnership with consumers. Sampled consumers said they were engaged in the assessment, planning and review of care and services. Nursing staff explained assessment and planning processes including how risks are identified and managed and that care, and service plans are reviewed when an incident or change to health status occurs. Training records indicate staff have received assessment and planning training including in relation to specific risks such as falls and behaviour management. Documentation showed initial assessment and planning occurred from day one of admission, including interim plans for respite consumers, with ongoing reviews scheduled at 3-monthly intervals. Accordingly, I find the service compliant with Requirement 2(3)(a).

The service was found non-compliant with Requirement 2(3)(e) following a site audit conducted in August 2022. The service at that time did not demonstrate care and services were always reviewed when circumstances changed, or incidents occurred. Reviews were not completed to implement new or evaluate existing preventative strategies for one sampled consumer who exhibited ongoing behaviours which impacted other consumers and staff. The service implemented remedial action including enhancing processes for completing assessment and planning, introducing greater oversight and review of incidents and staff training.

At this assessment contact, the service demonstrated that care plans, assessments and extended assessments are reviewed on a 3-monthly schedule and when changes or incidents occur. All sampled consumers expressed satisfaction with care planning following changes in care needs. Nursing staff explained care and service plans are reviewed when an incident or change to health status occurs. I have also considered evidence presented in Standard 3 of the assessment report in relation to the service conducting regular reviews of wound care and pain management for consumers with changing needs. Accordingly, I find the service compliant with Requirement 2(3)(e).

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The service was found non-compliant with Requirement 3(3)(a) following a site audit conducted from 23 August 2022 to 25 August 2022. The service at that time did not demonstrate effective management of wounds, restrictive practices and pain. The service implemented remedial action in response to the non-compliance identified at the site audit in August 2022 including completing informed consent documentation, reviewing and updating clinical policies and providing staff with clinical training.

At this assessment, while noting wound photography and measurements were sometimes inconsistent, the service demonstrated safe and effective wound care and pain management. Assessors recommended Requirement 3(3)(a) was not met as the service had demonstrated improvement in the area of effective wound care, however noted continued deficits in the management of restrictive practices. Review of the service’s psychotropic medication register demonstrated the register remains incomplete and does not identify consumers who are chemically restrained. As a result, there is ongoing risk associated with the monitoring, administration and identification of chemical restraint.

The Approved Provider submitted a response (the response) and supporting Plan for Continuous Improvement (PCI) which included further context and evidence of progress toward accurate and complete documentation related to chemical restraint in partnership with representatives and medical practitioners. I acknowledge the actions to date and future move to an electronic medication and clinical management system, however further time is required to ensure completion of these actions and a sustained improvement in practice once the implementation of the new systems and further monitoring of documentation has occurred.

Accordingly, I find the service non-compliant with Requirement 3(3)(a).

The service was found non-compliant with Requirement 3(3)(b) following a site audit conducted in August 2022. The service at that time did not demonstrate effective management of high impact or high prevalence risks associated with falls, changed behaviours, and diabetes management. The service implemented remedial action including staff training, updating behaviour support plans and introducing new insulin order forms.

At this assessment all sampled consumers were satisfied care is effectively managed and staff demonstrated understanding of high impact and high prevalence risks. The service demonstrated mostly effective management of changed behaviours and insulin management. However, the service did not demonstrate neurological observations consistently occur after consumers experience a fall.

In response to the assessment report the response indicates updates have been made to the falls prevention policy with staff to perform neurological observations following unwitnessed falls. While monitoring of this intervention is ongoing further review to ensure this approach has been imbedded in practice is required.

Accordingly, I find the service non-compliant with Requirement 3(3)(b).

The service was found non-compliant with Requirement 3(3)(e) following a site audit conducted in August 2022. The service at that time did not demonstrate consumer care information was documented and communicated between staff. Information in monitoring charts, care planning documentation, assessments, and medication charts was not always consistent. The service has implemented remedial action in response to the non-compliance including the introduction of a revised handover processes and documentation and rostering additional nursing staff to support handover.

At this assessment contact, the service demonstrated mostly effective internal communication of consumer care information. All sampled consumers and most consumer representatives said consumer needs and preferences are communicated in a timely manner. While assessors noted some inconsistencies and omissions in pain and behaviour charting, nursing and care staff described a comprehensive handover process and observed handover to be thorough and comprehensive with each consumer discussed in detail. Accordingly, I find the service compliant with Requirement 3(3)(e).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was found non-compliant with Requirement 7(3)(d) following a site audit conducted in August 2022. The service at that time did not demonstrate regular review of the training, learning and development needs of the workforce. Clinical staff did not feel equipped to complete mobility, equipment and falls assessments. The service has implemented remedial action in response to the non-compliance including providing mandatory clinical education for nursing staff and recruitment of a full-time physiotherapist.

At this assessment contact, the service demonstrated significant achievements in reviewing recruitment and induction practices and the ongoing training needs of all staff across the service. Sampled staff expressed satisfaction with the quality of training materials and that their everyday practice has benefited from the training. The service demonstrated high mandatory training completion rates and assessors observed a comprehensive training schedule. Accordingly, I find the service compliant with Requirement 7(3)(d).

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| 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. | Non-compliant |

Findings

The service was found non-compliant with Requirement 8(3)(c) following a site audit conducted in August 2022. The service at that time did not demonstrate effective governance systems in relation to information management and regulatory compliance. The service has implemented remedial action in response to the non-compliance including reviewing and updating policies and procedures and enhancing networking within the sector.

At this assessment contact, the service demonstrated progress towards achieving effective governance systems in relation to information management and regulatory compliance. Management explained in detail and demonstrated that planned improvements have been recorded in the service’s plan for continuous improvement, and were in process, however, were yet to be implemented. At the time of this assessment policies and procedures available to the workforce remain outdated, and the service did not clearly demonstrate meeting of legislative requirements associated with restrictive practices.

The Approved Provider submitted a response (the response) and supporting Plan for Continuous Improvement (PCI) which included further information regarding the implementation of upgrades to the electronic medication prescribing and charting systems as well as future actions related to medical record systems. The response and PCI also indicate an updated policy manual will be distributed to the workforce once approved by the Board, with individual policies distributed in the interim. While I acknowledge these improvements and future actions, the response confirms this as a long-term item requiring remediation which may continue to pose significant risk if not implemented adequately. As a result, evaluation and further time is required to ensure the proposed actions are effective to address previously identified deficits.

Accordingly, I find the service non-compliant with Requirement 8(3)(c).

The service was found non-compliant with Requirement 8(3)(d) following a site audit conducted in August 2022. The service at that time did not demonstrate an effective risk management system, including a lack of policies and procedures to guide staff on the identification and management of high impact and high prevalent risks, response to abuse and neglect of consumers and incident management. The service has implemented remedial action in response to the non-compliance including obtaining consent for all consumer subject to chemical restrictive practice and updating policies relating to restrictive practices and pain management.

At this assessment contact, the service demonstrated improvements to risk management systems and sampled staff stated they had received training on incident reporting. Documentation evidenced management had implemented improved processes around incident management. Management said risks are being effectively managed through analysis of clinical data monitoring, trending, and risk mitigation strategies for individual consumers. Management demonstrated actions the service takes to reduce risks to posed consumers by changing behaviours such as referral to a specialist dementia service, speaking to family members and making changes to behaviour support plans. All incidents are discussed at staff handovers and any actions as a result are entered into the service’s plan for continuous improvement. Accordingly, I find the service compliant with Requirement 8(3)(d).

The service was found non-compliant with Requirement 8(3)(e) following a site audit conducted in August 2022. The service at that time did not demonstrate effective clinical governance, safety and quality systems. The service did not demonstrate it minimised the use of restrictive practices as restrictive practice was not always used as a last resort and the service’s policy did not align with legislative requirements. The service has implemented remedial action in response to the non-compliance including updating policies and procedures relating to the clinical governance framework including, antimicrobial stewardship, minimising the use of restraint, and open disclosure.

At this assessment contact, the service demonstrated work had commenced on an updated clinical governance framework, however this had not been fully implemented. Nursing staff did not demonstrate a clear understanding of antimicrobial stewardship or restrictive practices and documentation demonstrated that not all policies and procedures had been updated to reflect current best practice in alignment with regulatory and legislative changes.

The response and PCI demonstrate progression and updated policies for approval by the Board and distribution, however given these have not yet been finalised and staff have not been given the opportunity to fully review and adopt these in practice further monitoring and evaluation is required.

Accordingly, I find the service non-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)