Performance

Report

**1800 951 822**

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| Name of service: | Eyre Peninsula Old Folks Home |
| Service address: | 26 Flinders Highway PORT LINCOLN SA 5606 |
| Commission ID: | 6046 |
| Approved provider: | Eyre Peninsula Old Folks Home Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 October 2022 |
| Performance report date: | 15 November 2022 |

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 Eyre Peninsula Old Folks Home (**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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others;
* an email received from the provider dated 26 October 2022 indicating a response to the Assessment Team’s report would not be provided; and
* a Performance Report dated 30 March 2022 for a Site Audit conducted from the 8 February 2022 to 10 February 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | 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 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

Consumers are supported to take risks which enable them to live the best life they can. Care files sampled demonstrated where a consumer chooses to engage in an activity with an element of risk, risk assessments are completed which include discussions of risks with the consumers and/or representatives and strategies to mitigate identified risks. Risk assessment forms are reviewed as part of the care evaluation process every six months. Clinical and care staff were aware of sampled consumers’ falls risks and prevention strategies. Consumers and representatives sampled confirmed the service supports consumers to take risks if they choose to take them and assessments and strategies to minimise harm have been discussed with them and implemented. One consumer said staff and the Allied health staff consult with them regularly in relation to safety aspects of leaving the service independently and for use of mobility equipment.

For the reasons detailed above, I find Requirement (3)(d) in Standard 1 Consumer dignity and choice Compliant.

# 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 |

Findings

Requirement (3)(a) was found Non-compliant following Site Audit undertaken from 8 February 2022 to 10 February 2022 where it was found the service did not demonstrate that each consumer received safe and effective clinical care in relation to the identification and management of chemical restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Made adjustments to prompt staff and support processes, for example, an extra column has been added to the monthly psychotropic medication log for consent, and Behaviour support plan and the restrictive practices chart has a box to tick that discussions of risk have occurred.
* In consultation with the Medical officers, the restraint authorisation Medical officer signature section has been removed and the medication order is considered the authorisation by the Medical officer.
* Amended the monthly clinical manager’s report to monitor assessments and consents, diabetes management plans and blood glucose parameters, psychotropic medication use, Behaviour support plans and restrictive practice assessments.
* Redistributed the diabetic protocol to staff and conducted a diabetic clinical audit.

At the Assessment Contact, care files sampled demonstrated appropriate, individualised management and monitoring strategies had been implemented in relation to restrictive practices, diabetes management and wounds. For consumers sampled, Behaviour support plans were generally comprehensive and personalised; blood glucose monitoring had been undertaken in line with directives; and wound care had been attended to in line with management plans. Staff sampled were familiar with those consumers in their care, able to identify individual needs, such as pain or wounds and could describe how care was tailored to the consumer to optimise their health and well-being. Consumers and representatives sampled were satisfied that personal and clinical care provided is safe and effective.

For the reasons detailed above, I find Requirement (3)(a) 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)(e) was found Non-compliant following Site Audit undertaken from 8 February 2022 to 10 February 2022 where it was found the service did not demonstrate an effective clinical governance framework in relation to use and management of restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Completed a gap analysis of the clinical governance system for the management of Behaviour support plans and restrictive practices. Consent and authorisations forms, psychotropic medications checking sheets, charting and registers are now aligned and in place with the current protocols and Standards/requirements.
* Implemented restrictive practices assessment and authorisation forms for consumers subjected to restrictive practices with processes to guide staff practices.
* Developed and implemented Behaviour support plans for consumers subjected to restrictive practices in line with the service’s Restrictive practices minimisation and use practice policy and legislative requirements.
* Introduced monthly Restrictive practice audits, which included psychotropic medications, environmental restrictive practices and Behaviour support plan forms. A register now maintained of Behaviour support plans and restrictive practices.
* Ongoing staff education provided in relation to Behaviour support plans and restrictive practices.

At the Assessment Contact, effective clinical governance systems and processes were demonstrated, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. The organisation’s clinical governance framework is supported by a Clinical governance guide which defines the roles and responsibilities of the Board and management. Policies and procedures relating to antimicrobial stewardship, restrictive practices minimisation and use practice, feedback and complaints, inclusive of an open disclosure framework, are available to guide staff practice. Use of restrictive practices are discussed and monitored at monthly clinical forums. Care staff sampled described strategies and alternative interventions implemented to reduce use of antimicrobials, including use of non-pharmacological strategies. Feedback and complaints documentation sampled, and management feedback demonstrated, complaints are documented, managed and resolved in accordance with the organisation’s policy and process and an open disclosure process is initiated, where required.

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)