Performance

Report

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| Name of service: | Matthew Flinders Home Inc |
| Service address: | 61-63 Oxford Terrace PORT LINCOLN SA 5606 |
| Commission ID: | 6951 |
| Approved provider: | Matthew Flinders Home Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 7 February 2023 |
| Performance report date: | 7 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 Matthew Flinders Home Inc (**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 Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others; and
* the Performance Report dated 17 November 2021 for the Site Audit undertaken from 12 October 2021 to 14 October 2021.

The provider did not submit a response to the Assessment Team’s report.

# 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 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

Requirement (3)(d) in Standard 1 Consumer dignity and choice was found non-compliant following a Site Audit undertaken from 12 October 2021 to 14 October 2021 where it was found activities involving risk had not been identified, assessed and appropriate strategies to mitigate risks implemented for three consumers, in line with the service’s policy. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the Care recipient right to risk taking policy and procedure.
* Developed a Risk register and clinical guidelines for staff to identify and assess risks.
* Reviewed and updated Risk forms to include cognitive and dexterity impairment.
* Provided training to clinical staff on risks, guidelines and revised policy documents and managing the prevalence of risks in aged care.

At the Assessment Contact undertaken on 7 February 2023, the Assessment Team recommended Requirement (3)(d) met. The Assessment Team’s report provided the following evidence relevant to my finding:

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 and consent forms are completed which include discussions of the activity and associated risks with the consumers and/or representatives and strategies to mitigate identified risks. Medical officers and/or Allied health professionals are also involved in assessment processes, where required. However, risk assessments had not been completed for three consumers who had single bed rails. Management said they are in the process of assessing these and other consumers, including assessment by the Physiotherapist. Lifestyle and care staff were aware of consumers who are supported to take risks and strategies to mitigate risks. Consumers sampled recalled being assessed by Allied health specialists and described strategies which had been implemented to enable them to partake in activities safely.

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

# 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 |

Findings

Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers was found non-compliant following a Site Audit undertaken from 12 October 2021 to 14 October 2021 where it was found processes to ensure each consumer had appropriate assessments completed to inform and develop the strategies in each consumer’s care plan were not effective. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed assessment and care planning, clinical care, care and service delivery policies and procedures.
* Reviewed care and management plans for all consumers with risk activity, changing behaviour, pain and restrictive practices.
* Provided training for clinical staff in relation to assessment, planning, monitoring and review of pain, behaviours and restrictive practices.

At the Assessment Contact undertaken on 7 February 2023, the Assessment Team recommended Requirement (3)(a) met. The Assessment Team’s report provided the following evidence relevant to my finding:

Care files sampled demonstrated a range of assessments are undertaken on entry, every three months and as required to determine consumers’ clinical care needs. A range of validated tools, including in relation to pain, falls, mobility and behaviour contribute to the assessment process. Assessments are completed in consultation with the consumer and/or representative, with information gathered used to inform development of personalised care plans and Behaviour support plans. Consumers and representatives expressed satisfaction with the care provided and advised action is taken promptly and communicated to them where risks are identified, or when consumers’ care needs change.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers 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 |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirements (3)(a) and (3)(g) in Standard 3 Personal care and clinical care were found non-compliant following a Site Audit undertaken from 12 October 2021 to 14 October 2021 where it was found the service had not ensured:

* clinical care in relation to pain and restrictive practices was managed in line with best practice or with the service’s policies and procedures; and
* ongoing review and updates of the COVID-19 outbreak management plan or that staff and management had the information and resources to manage an outbreak.

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

* Provided training to all clinical staff on pain, changing behaviour, identifying triggers and management strategies, reporting incidents, Standards and commencement of wound and pain assessments following podiatry procedures.
* Updated Pain management and Clinical pathway forms to include podiatry assessment and consent for small surgical procedures.
* Created a Restrictive practice register, and updated Environmental restraint and Consent forms and added them to the consumer entry pack. The keypad access/exit code to the main building and memory support unit have also been added to the entry pack.
* Reviewed the COVID-19 management plan to include, but not limited to, identification of the roles and responsibilities of key personnel; how consumers will access medical and allied health services; reviewed and updated zoning and cohorting of consumers and staff in the event of an outbreak; and identified additional procedures for ancillary staff in the event of an outbreak.
* Established a communication pathway with SA Pathology to ensure timely sharing of consumers’ pathology results prior to prescribing antibiotics.
* Provided additional antimicrobial stewardship education to clinical staff and reviewed the Antimicrobial clinical pathway.

At the Assessment Contact undertaken on 7 February 2023, the Assessment Team recommended Requirements (3)(a) and (3)(g) met. The Assessment Team’s report provided the following evidence relevant to my finding:

**Requirement (3)(a)**

Care files were reflective of consumers’ individualised personal care needs and demonstrated appropriate management of specific aspects of personal and clinical care, including pain, changing behaviours and restrictive practices. Clinical and care staff were familiar with sampled consumers’ personal and clinical care needs, including pain and changing behaviour management, and described best practice guidelines in relation to clinical care, and use of non-pharmacological interventions prior the consideration of chemical restraint for consumers. Staff said they have undertaken training in pain, dementia and restrictive practices and policies and procedures are available to guide practice. All consumers were satisfied with the personal and clinical care provided, including support provided for activities of daily living and pain management.

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

**Requirement (3)(g)**

Clinical staff described processes for identification and management of consumer infections consistent with infection prevention and control and antimicrobial stewardship principles. Care staff were knowledgeable of standard and transmission-based precautions to prevent and control infections and were observed adhering to infection control practices. Care files confirmed identification and management of consumers with short and long term infections, with best practice strategies to resolve or manage infections. Policies and procedures, as well as staff training programs ensure ongoing guidance and support to minimise infection related risks to the residential population. Consumers and representatives were satisfied that the service communicates and effectively manages infection related risks.

For the reasons detailed above, I find Requirement (3)(g) 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) in Standard 8 Organisational governance was found non-compliant following a Site Audit undertaken from 12 October 2021 to 14 October 2021 where it was found appropriate action had not been taken to review and implement Behaviour support plans for consumers where restrictive practices were in place. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed and consolidated consumer information into comprehensive and individualised Behaviour support plans that align with legislative requirements.
* Reviewed Allied health communication processes to ensure consumer care provision is provided in line with current assessed needs and with the appropriate consents in place, specifically regarding use of any form of restrictive practice.

At the Assessment Contact undertaken on 7 February 2023, the Assessment Team recommended Requirement (3)(e) met. The Assessment Team’s report provided the following evidence relevant to my finding:

A clinical governance framework, supported by organisational policies, procedures, systems and processes is in place to inform clinical care and services. An antimicrobial stewardship policy outlines the organisation’s approach to the ongoing monitoring of infections and responsible use of antimicrobials. Tracking, analysis, trending and reporting processes are undertaken with reporting to the Clinical governance committee ensuring clear clinical oversight. Restrictive practice policy documents support and guide staff in the responsible use of restrictive practices and reflect current legislative and regulatory requirements. Assessment, review, monitoring and reporting processes, as well as staff education are undertaken to minimise restrictive practice use. There are processes to monitor and reduce the use of restrictive practice, including weekly review of all consumers’ progress notes to identify increased or decreased use of as required psychotropic medications for behaviour management and consultation with treating Medical officers to reduce or cease unnecessary medications. An open disclosure policy supports staff practice when things go wrong, with incident reporting and review processes undertaken to ensure appropriate investigation to identify strategies for the prevention of reoccurrence. Clinical governance updates are provided by the management team to the Chief executive officer and Board to ensure they are informed of clinical indicators, incidents, workforce and other relevant issues.

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)