Performance

Report

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| Name of service: | Polish Retirement Home |
| Service address: | 3 Percival St BAYSWATER VIC 3153 |
| Commission ID: | 3189 |
| Approved provider: | Australian-Polish Benevolent Association of Victoria Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 December 2022 to 7 December 2022 |
| Performance report date: | 13 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 Polish Retirement Home (**the service**) has been prepared by L. Malone, 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 3 Personal care and clinical care | 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 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

The service was previously found Non-complaint in Requirements 3(3)a and 3(3)g under this Quality Standard.

A site audit from 21 to 22 April 2021, and follow-up Desk Assessment between 14 and 21 September 2021 found the service to be Non-complaint in Requirement 3(3)a. The service did not demonstrate care that is best practice and tailored to the individual. Pain observations were not found to be recorded consistently using standardised assessment tools, descriptions, pain scores. Pain management care plans were not found to be individualised or consider non-medication strategies, and consumers with prescribed restrictive practice were not reviewed in line with service’s policies and legislative requirements.

The service has implemented actions to address the previous Non-compliance and implemented new electronic care management system which supports some of these actions. The actions were found to be effective in rectifying the previous issues of non-compliance and the service was found to demonstrate care that is tailored to the individual, optimises wellbeing and aligns with best practice.

In relation to the use of chemical restrictive practices, the service was able to demonstrate processes to support minimisation and use of the least restrictive form of practice. A review of care files found all consumers prescribed psychotropic medication for the management of behaviours had documented informed consent which detailed the risks and indicators for their administration. Consumers subject to chemical restraint had individualised support plans and were found to be regularly reviewed by a medical practitioner and geriatrician. Staff were able to provide information related to behaviours, strategies, medication and risks for individual consumers.

The service demonstrated effective assessment, monitoring and management of pain. Care files reviewed found evidence of detailed pain assessment, the use of non-medication and medication strategies, in addition to monitoring the effectiveness of interventions. Consumers interviewed regarding their pain reported being comfortable.

Care files provided evidence of wound care in line with the service’s policy and documented care in line with recommendations of the care plan. The service engages a wound specialist when required and care is provided in line with their recommendations.

The service was found Non-compliant with Requirement 3(3)g on 26 April 2022 following issues identified between 21 April and 25 April 2021. The service did not demonstrate effective management of COVID-19 outbreak at that time. The service did not have an Infection Control and Prevention Lead (IPC Lead) onsite, did not implement standard and transmission-based precautions appropriately and staff did not demonstrate correct use of personal protective equipment (PPE).

The service demonstrated evidence of actions taken to address the previous Non-compliance and effectively demonstrated minimisation of infection transmission risk including risk of COVID-19 transmission. These actions included a review of their outbreak management plan in relation to zoning areas, allocation of clear roles to staff and surge workforce planning. The service has a dedicated IPC Lead responsible for the implementation of infection control practices and education of staff. The service demonstrated evidence of regular and ongoing PPE and handwashing education provided to staff with the Assessment Team observing appropriate use of PPE by staff.

I am satisfied by the evidence presented that the service has taken effective actions to address the previous issues relevant to this Quality Standard and find Requirements 3(3)a and 3(3)g to be Compliant.

# 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

The service was previously found Non-complaint in Requirement 7(3)a under this Quality Standard on 26 April 2021, as the service failed to demonstrate effective surge workforce planning and did not ensure deployment of the number and mix of staff to deliver safe and quality care.

The service implemented the following actions in response to the Non-compliance which were found to be effective, including a review of the shift allocation model, upskilling of current staff, ensuring a registered nurse is rostered across all shifts (24 hours a day) and recruitment of a clinical care coordinator.

Consumers provided positive feedback indicating they are satisfied there is enough staff at the service. The Assessment Team reviewed rostering and shift allocation documentation finding planned and unplanned leave to be covered effectively. Staff were observed answering call bells promptly and spending one on one time with consumers.

I am satisfied by the evidence presented that the service has taken effective actions to address the previous issues and find Requirement 7(3)a Compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Compliant |

Findings

The service was previously found Non-complaint in Requirements 8(3)d and 8(3)e under this Quality Standard.

The service was previously found Non-compliant in Requirement 8(3)d on 26 April 2021, as the service did not demonstrate effective risk management systems and practices managing COVID-19 outbreak, or effective medication management with staff performing ad hoc roles without appropriate qualification to administer medications. The service did not demonstrate effective handover and risk to continuity of care was identified.

Actions documented on the service’s continuous improvement plan to rectify the issues of Non-compliance were found to be implemented and effective. The service introduced a new electronic medication management system and competency requirements for staff, defined roles and scope of practice, medication audits and developed a new handover tool. The Assessment Team reviewed the service’s risk framework in addition to relevant policies and found staff understood the relevant policies and their responsibilities in identifying, reporting and managing risk and incidents. The service demonstrated effective oversight and monitoring of risk through daily review of incidents by management and monthly data reporting.

The service was previously found Non-compliant in Requirement 8(3)e during a site audit 21 April to 22 April 2021. An ongoing non-compliance was identified following a Desk Assessment Contact between 14 and 21 September 2021. The service did not demonstrate an effective clinical governance framework in relation to chemical restraint and pain management, effective monitoring of consumers on psychotropic medication, compliance with service’s policy on the use of chemical restrictive practice by staff, management and external care providers.

The service has taken actions to rectify the previous issues of Non-compliance such as a review of restrictive practice and pain management policy, review of restrictive practice consent forms to include risks of the medication, improved processes of monitoring and ongoing review of consumers on psychotropic medications by registered nurse, general practitioner and geriatrician. The Assessment Team sighted policies and documented work instructions to support staff practice and care documentation provided evidence of regular monitoring and review, in addition to care in line with these policies. Staff demonstrated knowledge of principles of antimicrobial stewardship, minimising the use of restrictive practice and open disclosure and how clinical governance framework, or specific policies related to practice, and the service presented evidence of relevant training.

I am satisfied by the evidence presented that the service has taken effective actions to address the previous issues and find Requirement 8(3)d and 8(3)e 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)