Performance

Report

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| Name: | Sunnyside House |
| Commission ID: | 3015 |
| Address: | 1 Adeney Street, CAMPERDOWN, Victoria, 3260 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 3 July 2024 |
| Performance report date: | 5 August 2024 |
| Service included in this assessment: | Provider: 803 Sunnyside House Inc  Service: 1774 Sunnyside House |

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 Sunnyside House (**the service**) has been prepared by G. Harbrow, 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 (performance assessment) – 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 26 July 2024.

# 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 | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not 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.

* Requirement 8(3)(e)

Establish and effectively demonstrate the service has a system or process of clinical governance, reflective of the relationships and or responsibilities between the organisation’s governing body, executive, clinicians, and consumers to achieve effective clinical outcomes; particularly in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure.

# 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

Consumers and representatives said they receive the care and services they need. Staff could describe the assessment and care planning process, and how they used outcomes to inform the delivery of effective care and services to consumers. However, the Assessment Team identified consumer care planning documents were incomplete and therefore unable to effectively inform safe delivery of care and services.

The Assessment Team determined the service’s policy regarding assessment and care planning, requires interim care plans to be completed within 24 hours of consumer admission, with completion of a comprehensive care plan within 30 days. The policy further indicates a consumer care plan review required every 2 months. The Assessment Team identified consumers did not have completed comprehensive care plans, and or reviews aligned with service policy timeframes. They found identified changes in consumer condition had not been updated in care plan documents nor had further assessment been conducted to determine new and or potential risk or mitigation strategies. The Assessment Team identified staff did not consistently document in charts to record aspects of consumer care, however, this care was documented in consumer progress notes.

Management acknowledged the delay in developing comprehensive care plans. They provided the Assessment Team with a planned roster, indicating clinical shifts allocated for the purpose of consumer care plan review, and update.

Management and clinical staff advised the admission assessment and care planning process is used to inform an interim care plan with initial assessment to include consideration of numerous prioritised risks associated with consumer care needs. Management and clinical staff further advised they compare information from previous consumer assessments, consumer health summaries, and information provided by consumers and representatives.

The Assessment Team identified, and management confirmed comprehensive staff handover sheets and interim care plans to reflect consumers’ current care needs and preferences. The Assessment Team further confirmed the use of these documents to inform consumer care delivery according to current consumer needs.

The Provider submitted a written response (the response), including information to rectify inaccuracies identified in the Assessment Team Report. I acknowledge and accept the inaccuracies as identified by the Provider. The response advised and supporting documentation confirmed, consumer care planning documents and or charting identified in the Assessment Team report as incomplete, to have been complete at the time of the performance assessment. The response confirmed a process of regular and as required care plan review as per service policy. This was supported by consumer care documentation.

The Assessment Team recommended Requirement 2(3)(a), as not met. However, with consideration to the information available to me, I have come to a different view and am satisfied the service has demonstrated strategies in place to address the identified deficits, and as a result, is compliant with this Requirement. I encourage the service to continue to implement actions and improvements as indicated to the Assessment Team during the Performance Assessment, and in the Assessment Team Report.

# 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

The Assessment team found the service did not demonstrate best practice when unable to demonstrate effective charting of consumer care episodes and experience related to pain. However, the Assessment Team report indicates effective assessment of pain, evaluation of pain care interventions, and alternate pain mitigation strategies documented in consumer progress notes and care files.

The Provider submitted a response (the response), including information to rectify inaccuracies identified in the Assessment Team Report in relation to pain assessment and management. I acknowledge and accept the inaccuracies as identified by the Provider.

The Assessment Team identified management was unable to identify consumers subject to environmental restrictive practice and staff were unable to describe what constitutes environmental restraint.

The Assessment Team report indicates several consumers were identified as unable to exit the service independently. Service management advised of these consumers living with medical conditions and diagnoses assessed as presenting a risk to independent exit of the facility. The Assessment Team determined these consumers and or representatives had not provided informed consent for environmental restraint and the consumers did not have behaviour support plans in place. Management acknowledged they had been unaware the consumers were subject to restrictive practices and confirmed this was not aligned to the service’s policy and best practice guidelines.

In response to the Assessment Team’s findings, management provided an updated plan for continuous improvement (PCI) which included a plan to identify consumers subject to environmental restrictive practice, undertake assessments and obtain informed consent for use of restrictive practices. The PCI described development of behaviour support plans for all consumers subject to environmental restrictive practice.

The Provider submitted a written response (the response) indicating the remediation of identified deficits including discussions with consumer representatives to initiate behaviour support plans and obtain consent for environmental restraint. The response evidenced appropriate identification of consumers subject to environmental restraint with personalised behaviour support plans. While provision of consent is indicated on the support plans for 5 consumers, evidence of consent for 2 consumers was not, with one of these consumers identified as reluctant to exit the service environment at any time.

The Assessment Team recommended Requirement 3(3)(a) as not met. However, in consideration of the service’s responsiveness to the identified deficits, absence of consumer impact and consideration of proportion, I have come to a different view and consider Requirement 3(3)(a) as compliant. I encourage the service to continue to implement actions and improvements as identified in the response to be included in the service’s PCI.

# 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. | Not Compliant |

Findings

The Assessment Team found the service did not demonstrate an effective governance framework in relation to assessment, identification, and minimisation of environmental restrictive practice.

The service has an updated policy on restrictive practice; however, the Assessment Team determined the policy did not provide sufficient detail and identification, related to the use of a code protected entry and or exit point as an environmental restraint. The Provider submitted a response (the response), including the service’s current policy on restrictive practices. The policy includes referenced restrictive practice definitions from the Department of Health and Aged Care 2022. I am satisfied with the definitions provided in this policy to effectively identify environmental restraint.

Management and clinical staff were unable to identify consumers subject to environmental restraint and were unable to explain the associated legislative requirements. The Assessment Team found no process in place to monitor and report the use of environmental restrictive practice to management and the Board.

The Assessment Team determined the service to have policies on antimicrobial stewardship and open disclosure to provide guidance to staff on expected practice. The Assessment team found the service had provided education to staff in relation to minimising antibiotic use and the process of open disclosure.

The Provider submitted a written response (the response) indicating staff education records for restrictive practice education were available to the Assessment Team during the performance assessment. The response included a comprehensive list of staff who had completed this education.

The Assessment Team recommended Requirement 8(3)(e) as not met. I have considered the information available to me, including the Approved Provider’s response, and I encourage the Approved Provider’s further consideration of the intent of this Requirement. While I acknowledge the valuable contribution of policy and staff education, I am not satisfied, the service has effectively demonstrated a system or process of clinical governance, reflective of the relationships and or responsibilities between the organisation’s governing body, executive, clinicians, and consumers to achieve effective clinical outcomes overall. As a result, I have determined the service is not 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)