Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Trinity Manor |
| Service address: | 10-14 Pretoria Street DEEPDENE VIC 3103 |
| Commission ID: | 4158 |
| Approved provider: | Trinity Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 October 2022 to 19 October 2022 |
| Performance report date: | 22 November 2021 |

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 Trinity Manor (**the service**) has been prepared by L Glass 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

|  |  |
| --- | --- |
| 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 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **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 2

|  |  |  |
| --- | --- | --- |
| 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

The service was found non-compliant in Standard 2 in relation to Requirements 2(3)(a) following a site audit in February 2022. Care planning documents did not include a behaviour support plan specific to psychotropic use and chemical restraint and risks did not inform care planning.

The Assessment Team found the service demonstrated improvements in assessment and planning and consideration of risks informing consumer care. The service undertakes an assessment process when consumers first enter the service to ensure all relevant information is captured to ensure safe and effective care and services are delivered to all consumers. Care planning documentation demonstrated a range of clinical risk assessment tools are used to complete assessments on entry, including for skin, mobility, nutrition and hydration, falls, behaviour and medication and, if required wound and diabetes management.

Where risk is identified through assessment processes, management strategies are implemented to minimise associated risks. Staff explained the assessment process, how risks are identified and how consumers and representatives are involved in assessments. A consumer and 2 representatives confirmed involvement in assessment and planning, including in relation to risks to consumer health and well-being.

Three consumers reviewed had chemical restraint identified to manage behaviours. Assessments included a risk rating (Elder Risk Impact Rating) with risks such as side effects identified. Behaviours support plans and consent forms for chemical restraint were in place.

Pain assessments are completed. The service utilises Abbey Pain Scales for consumers who are unable to verbalise their pain. Four consumers files viewed demonstrated when potential or actual pain was identified, pain assessments were completed and analysed by clinical staff, for example, for wound pain and potential pain following a fall. Complaints of pain were all actioned in line with the service’s pain management process.

I am satisfied the service demonstrated it undertakes assessment and planning and considers risk to inform the delivery of care and services. Interviews with consumers, representatives and staff documentation review and observations at the service confirmed improvements have been made since the last assessment. I find requirement 2(3)a Compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 found non-compliant in Standard 3 in relation to Requirements 3(3)(a) and 3(3)(g) following a site audit in February 2022. The service was not able to demonstrate clinical care related to wound management or chemical restraint were consistently in line with best practice. The service did not recognise consumers who were chemically restrained and had not considered or assessed risks associated with chemical restraint. The service did not minimise the use of chemical restraint or ensure consultation and informed consent had been obtained.

The Assessment Team found the service demonstrated improvements have been made since the site audit and consumers receive safe and effective personal and clinical care. Care plans reflected best practice principles. Individualised care addressed consumer needs, goals and preferences in consultation with consumers and/or their representatives and where required in collaboration with health providers external to the service.

Consumers and/or their representatives are satisfied with the tailored care the service provides to consumers, particularly with the management of consumer’s wounds, pain and personal care. Wound specialists are engaged to advise and consult about wound healing.

Restrictive practices including chemical restraint is managed in accordance with legislative requirements. Consumers are reviewed, consultation occurs, consent is obtained and there is ongoing monitoring of consumers. Clinical staff explained non-pharmacological interventions for individual consumers are trialled prior to administering medications and monitoring is documented for example, for behaviour, for pain using the Abbey pain scale and sight charting informs management of consumer behaviour. Clinical and care staff demonstrated knowledge of individual consumers and skill in managing clinical and personal care of consumers.

I find the service demonstrated improvements are in place since the site audit in February 2022 and clinical and personal care is delivered safely and effectively and tailored to individual consumer needs. Consumers and their representatives confirmed their satisfaction with the care and services delivered. Staff were knowledgeable about best practice approaches to care, knew individuals and their care needs, engaged specialists when needed and implemented legislative requirements. I find requirement 3(3)a Compliant.

The Assessment Team found the service demonstrated improvements in the minimisation of infection and related risks and preparedness in the event of an infectious outbreak. All staff were observed wearing personal protective equipment (PPE) appropriately, including staff in the consumer facing areas of the service. Clinical staff demonstrated understanding of antimicrobial stewardship (AMS) and infection control describing ways to minimise and manage them. Infections are monitored, recorded, collated and trended monthly. Infections, AMS and antiviral medications are standard items discussed in the clinical staff meetings and medical advisory committee (MAC).

Consumers and their representatives are satisfied with the service’s management of infections and the prescribing of antimicrobials. Representatives understood the rationale for the screening process in place at the service. The service has 2 infection prevention and control (IPC) leads. The service has an outbreak management plan that has been reviewed and practised.

I find the service demonstrated improvements in the implementation of strategies to minimise infection related risks since the site audit in February 2022. An Outbreak Management Plan is in place and it has been reviewed and practised. Antimicrobial stewardship is understood and practised by staff. I find requirement 3(3)g Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

The Service was found non-compliant in Standard 8 in relation to Requirement 8(3)(e) following a site audit in February 2022. The service was not able to demonstrate The service demonstrated the organisation’s clinical governance framework includes policies and practices for antimicrobial stewardship, minimising the use of restraint and open disclosure.

Clinical staff were able to describe the concepts of antimicrobial stewardship, the measures taken to reduce the use of antibiotics and how this is discussed with the medical practitioners, consumers and their representatives when infections are identified.

The service has 2 fully trained infection prevention and control leads. The service manager and corporate services manager oversee the service’s infection rates and associated actions.

Management demonstrated an understanding of requirements in relation to minimising restraint, different aspects of restrictive practices, and application as per the organisation’s restrictive practice policy. Clinical and care staff demonstrated understanding of restrictive practice and their roles in monitoring and reviewing consumers subject to any restrictive practices.

Where restraint is used at the service, it is recorded on a restraint assessment form, monitored and evaluated for effectiveness and discussed with the consumer, their representative and general practitioner. A review of the training records demonstrated that staff have participated in training around restrictive practices and the subject is included in staff and medication advisory committee meeting minutes.

Clinical and care staff were familiar with the specific term ‘open disclosure’, they demonstrated an understanding of the practices which support open disclosure such as acknowledging an incident and apologising.

I am satisfied the service demonstrated it has an effective clinical governance framework, staff implement the relevant policies, practices and procedures that underpin the framework and demonstrated knowledge of applicable legislative requirements. Open disclosure is understood and practiced. I find requirement 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)