Performance

Report

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| Name of service: | Villa Del Sole |
| Service address: | 73 William St GLENROY VIC 3046 |
| Commission ID: | 3544 |
| Approved provider: | Securo Care Proprietary Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 August 2023 |
| Performance report date: | 07 September 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 Villa Del Sole (**the service**) has been prepared by D. Fekonja, 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.
* the provider’s response to the assessment team’s report received on 21 August 2023.
* Plan for Continuous Improvement received on 22 August 2023.

# 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 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

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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

The service was found non-compliant with Requirement 2(3)(a) at a Site Audit conducted from 28 February 2023 to 2 March 2023. The service did not demonstrate consistent consideration of risk for consumers to support the safe delivery of care. Risk assessments have not been completed for consumers who have clinical risk factors. Initial assessments and care planning were not always undertaken when consumer risk was identified or on admission to the service.

The service has implemented improvements to rectify the identified deficits. These include:

* The review of one consumer care plan per week to ensure all care plans are reviewed, completed, updated, and accurate.
* Staff education provided in relation to risk assessment including behaviour support plan completion.

During the assessment contact conducted on 3 August 2023, the review of 9 consumer files demonstrated an improvement in the assessment and planning of consumers’ risks related to skin integrity, pressure injury, falls and swallowing difficulties. This was done in consultation with the consumers and/or their representatives and the multidisciplinary health team.

Consumers and/or their representatives are satisfied with consumer care planning and are confident that consumer risks are identified and strategies to minimise harm to consumers are planned. The Assessment Team found whilst there has been some improvement in assessing and planning for consumers with risk factors, the service did not identify risks associated with restrictive practices. Although consent has been obtained behaviour support plans did not specify the reason for the use of the restrictive practice, the associated risks, or any mitigation strategies.

Although the Assessment Team recommended the service was not met in this Requirement, I have come to a different decision. The approved provider in its response provided evidence that the deficits in relation to the named consumers have been rectified. There have been improvements made in relation to restrictive practices ensuring all risks are identified and assessed.

I find the service is compliant with this Requirement.

# 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)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |

Findings

Requirement 3(3)(a) was found non-compliant following a Site Audit conducted from 28 February 2023 to 2 March 2023. The service did not demonstrate an understanding of the current restrictive practice legislation and did not identify consumers subject to chemical and restrictive practices. Care planning documents were incomplete and did not identify the consumers’ triggers for changed behaviours and behaviour management strategies were not being implemented.

The service demonstrated improvement in the delivery of safe and effective care and services through the actions implemented as specified in the service’s continuous improvement plan including:

* The provision of staff education and training on the appropriate use and management of psychotropic medications and restrictive practices.
* Obtaining a psychotropic report from the pharmacist to assist the service in monitoring the use of chemical restrictive practices.
* The review and completion and implementation of consumer assessment and care plans including the changed behaviours, triggers, and alternative strategies to manage the behaviours of concern.

During the assessment contact conducted on 3 August 2023, the service demonstrated improvement in the appropriate identification and management of consumers’ restrictive practices and the documents reflected a consistent review of consumers prescribed psychotropic medications. Consumers confirmed they have been consulted and have consented to the use of chemical and environmental restrictive practices and are satisfied with the management of consumers’ changed behaviours.

The Assessment Team provided evidence for one named consumer in relation to how the service effectively managed their chemical restrictive practice. The service had a range of intervention strategies in place that have been trialled in consultation with medical practitioners.

Requirement 3(3)(d) was found non-compliant following a Site Audit from 28 February 2023 to 2 March 2023. The service did not demonstrate that consumer deterioration was identified and managed in a timely manner. In particular, documentation did not reflect the identification and response to health changes such as the identification of wounds and episodes of coughing.

The service has implemented actions in response to the non-compliance which have been effective, including:

* The review and updating of key policies related to deterioration
* Increased monitoring of changes in consumer condition by clinical care manager review of progress notes
* Staff training on clinical conditions of relevance.

During the Assessment Contact on 3 August 2023, the service demonstrated effective identification and response to changes in consumer’s health status. The Assessment Team provided evidence in relation to a consumer with complex care needs and risks in relation to palliative care, pain management, and the risk of choking. The service was able to show all information was documented, monitoring maintained and appropriate clinical care provided to the consumer.

Based on the information provided in the Assessment Contact report I find the service compliant with Requirements 3(3)(a) and 3(3)(d).

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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

Requirement 8(3)(c) was found non-compliant following a Site Audit conducted from 28 February 2023 to 2 March 2023. The service did not demonstrate that appropriate actions are taken in relation to information management, continuous improvement, and regulatory compliance. Staff did not have access to the electronic management system and therefore this impacted the care provided to consumers. The organisation's systems and processes failed to effectively monitor and improve the quality and safety of the care and services provided by the organisation. The service was not compliant with restrictive practice legislation.

The service’s continuous improvement plan (CIP) outlined several actions the service has undertaken in response to the non-compliance. These include:

* Training for all staff related to psychotropic medications will be provided and the service will receive monthly psychotropic drug reports provided by the pharmacy.
* Review of the psychotropic register and consumers subject to restrictive practices to ensure this documentation is complete and current.
* Capturing feedback and complaints in the complaints register and following up on actions.
* The service is informing family members and new residents about environmental restraints and compulsory reporting with a new form that goes into the resident information pack.

During the Assessment Contact on 03 August 2023, the Assessment Team found whilst the service demonstrated improvement in information management systems, the service did not adequately demonstrate consistent effective organisation governance systems for continuous improvement and regulatory compliance.

Staff had adequate access to information on electronic systems relevant to their role and scope of practice, in order to perform their roles and provide quality care to consumers. They also had access to policies and procedures either from the electronic system, during staff meetings, or in printed form.

The Assessment Team found the service had outdated information in relation to restrictive practices that did not reflect current legislative requirements, especially in relation to the requirement of behaviour support plans. The continuous improvement register in place had not been updated since April 2023 and did not reflect gaps and deficits in consumer care and services that had been identified and documented in various meeting minutes. The service was also not able to provide data on clinical statistics and quality indicators.

The approved provider in its response provided evidence it had updated its policies and procedures in relation to restrictive practices and that they are reporting on clinical statistics and quality indicators. The continuous improvement plan has also been updated to reflect the improvements required in relation to restrictive practices, possible improvements to the electronic system, and training requirements.

Requirement 8(3)(e) was found non-compliant following a Site Audit conducted from 28 February 2023 to 2 March 2023. The service did not demonstrate that appropriate actions were taken in relation to clinical care, including, but not limited to antimicrobial stewardship, minimising use of restraint, and open disclosure.

The service failed to identify clinical risks to consumers in relation to restrictive practices, wounds, and changes in swallowing, and quality and safety were at risk. A clinical governance framework was still under development. Policies, including the clinical governance framework, infection control management, and antimicrobial stewardship, restrictive practices did not reflect current legislation.

The service has implemented actions in response to the non-compliance which include:

* The updating of a range of policies and procedures and incorporating them into the electronic system.
* Staff training on restrictive practices and restraints in May 2023 and June 2023 through the electronic learning platform, ‘Bridge Altura Online Training’.
* Further staff training for open disclosure is scheduled in the 2023 learning and development calendar for all staff to be provided on August 2023.
* Staff training in ’medication management – psychotropics’ was completed in April 2023.

During the assessment contact conducted on 3 August 2023, the Assessment Team found the service did not adequately demonstrate an effective clinical governance framework, particularly in relation to the assessment and planning of the use of restrictive practices for consumers and antimicrobial stewardship. The identification and management of restrictive practices and clinical risks to consumers have not been identified, assessed, and planned. Policies, and procedures to guide staff in the use of restrictive practices were not updated to reflect current legislative requirements. Policies, including the clinical governance framework, infection control management, and antimicrobial stewardship, restrictive practices did not reflect current legislation.

The approved provider in its response was able to show evidence of a range of policies that have been updated. They have had independent benchmarking audits in relation to the service's antimicrobial policy, clinical care delivery, and infection prevention and control conducted trends and analysis on infection rates.

All consumers who were named in the Assessment contact report will have their files reviewed to ensure all documentation is in line with legislative requirements.

Although the Assessment Team recommended that Requirements 8(3)(c) and 8(3)(e) were not met I have come to a different decision. This is based on the improvements made prior to the assessment contact conducted on 3 August 2023 and by the further information on improvements made as outlined in the approved provider’s response.

I find the service is compliant with Requirements 8(3)(c) and 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)