Braemar House

Performance Report

10 Windsor Road
EAST FREMANTLE WA 6158
Phone number: 08 9339 9449

**Commission ID:** 7758

**Provider name:** The Commissioners of the Presbyterian Church in WA

**Assessment Contact - Site date:** 7 January 2021

**Date of Performance Report:** 11 May 2021

# Publication of report

This Performance Report **may be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for 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 Approved Provider’s response to the Assessment Contact received 3 February 2021
* a complaint to the Aged Care Quality and Safety Commission received 23 November 2020.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(g) under Standard 3 Personal care and clinical care. All other Requirements in Standard 3 were not assessed.

The Assessment Team have recommended Requirements (3)(a) and (3)(b) not met and Requirement (3)(g) met. I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the Approved Provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(b) and Compliant with Requirement (3)(g). I have provided reasons for my finding in the specific Requirements below.

The service has policies, processes and assessment tools to effectively manage skin integrity, wounds and pressure injuries, weight loss and pain management. However, the service was unable to demonstrate each consumer receives safe and effective care which is best practice and tailored to consumers’ needs. The Assessment Team found on review of consumers’ case files, the service could not demonstrate behavioural responses and falls were managed, post incidents investigated, and high impact or high prevalence risks were assessed, monitored and evaluated. In addition, the service could not demonstrate correct use and documentation of physical and chemical restraints.

The Assessment Team found the service has effective prevention and monitoring systems to minimise risk of infections. Representatives said they observe staff engaging in positive infection control practices and the organisation provides regular updates on infection controls implemented at the service. Staff interviewed were able to demonstrate an understanding of best practice management of prescription antibiotics and infection related risks. The organisation has policies and procedures relating to infection control and antimicrobial practises to guide care and service delivery.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found the service was unable to demonstrate each consumer receives safe and effective clinical care which is best practice and tailored to their needs, specifically in relation to falls and behaviour management, and restrictive practises. In addition, post incidents are not effectively investigated, reviewed and actioned. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer who requires assistance to mobilise, was observed walking outside dragging a chair for support and displaying aggression towards other consumers. Documentation noted the consumer was a high risk of falls and between October to December 2020 the consumer had seven unwitnessed falls. Post assessment of falls showed inconsistencies in the documentation. The behavioural management plan has not been updated to capture the recommendations from Dementia Support Australia.
* Another consumer had been placed on a very ‘low bed’ and staff confirmed it was implemented to prevent the consumer getting out of bed during rest time, becoming upset, restless and wandering. Management advised there was not restraint authority implemented as it was assessed under the mobility and transfer assessment, however, due to the height of the bed from the ground, it was preventing the consumer from getting out of bed. In addition, the consumer was given psychotropic medication on a regular basis, there was no documentation to support trialled medications prior to use and four staff were unable to provide strategies to assist with the consumer’s emotional state.
* Psychotropic medication is administered regularly for another consumer to manage wandering, agitation and inability to settle. The consumer was observed to be asleep and seated in a lounge chair with a table placed in front of/over their legs, and staff said it was to prevent a fall and in preparation for lunch. The Assessment Team noticed the consumer was not woken at lunch time and their meal was served well after the service mealtimes. Care files indicate there has been no behaviour management plan implemented, no trialled medication strategies documented and no authorisation sought and/or discussed prior to the use of physical and chemical restraints.
* Staff interviewed said consumers’ needs are not met due to staff shortages and medications are used to manage consumers’ behaviour.
* Multidisciplinary meeting minutes from December 2020, indicate staff are to administer medications on a regular basis to reduce behavioural incidents and manage unmet behavioural needs.

The Approved Provider submitted a response to the Assessment Team’s report and asserts their commitment to meet their responsibilities as an Approved Provider and to address the deficiencies identified by the Assessment Team. The Approved Provider’s response includes a plan for continuous improvement to rectify the identified matters. Actions related to this Requirement include:

* Implement comprehensive clinical weekly reviews of all high-risk consumers by the High Acute Review Group and other consumers’ care and services will be reviewed during the Clinical Case Management meetings.
* Establish a site-specific Clinical Governance and Quality Improvement Team (CGQI) to drive stability in clinical management processes.
* Consumers’ psychotropic medication usage will be reported within the CGQI Team meeting and will be tracked by the Clinical Manager (iCare). This information, along with the behavioural charting will be provided to the General Practitioner every three months for further review and recommendations.
* Staff restructure to include the appointment of Care Services Manager and an additional Clinical Nurse.
* Incident forms were updated and the service implemented a weekly review of incidents to identify trends to guide best practice in the delivery of care and services. The Clinical Service Manager audit will occur monthly and will include reviewing the effectiveness of the management of falls and post falls strategies.
* Education has been provided to staff in fall prevention, behaviour management, and reporting and investigating incidents.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

I acknowledge the actions and improvements made by the service to rectify the deficiencies identified by the Assessment Team. However, I find at the time of the Assessment Contact, and for the consumers sampled the service was unable to deliver safe and effective personal and clinical care. I considered the observations of the Assessment Team and staff and representative feedback and find the service’s use of chemical and physical restraints was not aligned to best practice guidelines. For one consumer, management advised a physical restraint was applied to prevent falls, however, there was no authorisation sought and no consultation occurred with the consumer and/or representatives. Two consumers were receiving psychotropic medication to manage their behavioural responses without trialling alternative strategies. Post incident behaviour and falls management for one consumer sampled was not effectively managed or evaluated and recommendations from a health specialist not implemented.

For the reasons detailed above, I find, The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Requirement (3)(a) in Standard 3.

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with care and services, specifically in relation to physical, verbal and wandering behaviours of five consumers which were having a negative impact on other consumers in the service. In addition, staff were not supervising consumers who are at high-risk of falls and strategies are not implemented/managed after an incident has occurred. The Assessment Team provided the following information and evidence relevant to my finding:

* Progress notes and behaviour charting for a consumer sampled indicates a high incident of physical and verbal aggression towards other consumers and staff, although, all incidents have not been recorded on the incident register. In addition, the behaviour care plan does not identify the triggers of this behaviour and/or if the strategies implemented are effective. However, I do acknowledge the consumer has been referred to Older Adult Mental Health unit.
* For another consumer, the behavioural chart shows several incidents of physical aggression, agitated and intrusive behaviour towards both consumers and staff. The progress notes indicated the consumer was referred to Dementia Services Australia, however, the recommendations are not identified on the behaviour care plan. Medication is listed as a strategy to manage the behavioural responses.
* Another consumer is displaying ‘wandering behaviours’ and attempts to leave the service unaccompanied. Although the handover documentation notes staff are to perform 15-minute visual sighting, it is inconsistent with the behaviour care plan noting a strategy to manage the behaviour is to administer medications on a regular basis.
* In addition, the Assessment Team observed sighting charts being completed at the end of a shift rather than each time checks were performed.

The Approved Provider submitted a response to the Assessment Team’s report and provided a continuous improvement report to ensure the identified areas of deficiencies have been addressed. The Approved Provider listed improvements already captured in Standard 3 Requirement (3)(a). Although, the continuous improvement plan refers to a colour coding chart to alert staff of high impact or high prevalence risks associated with the care of each consumer, it does not inform how risk assessments will be used to reduce and/or monitor the strategies for effectiveness.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

My finding is at the time of the Assessment Contact, the service was not effectively managing the high impact or high prevalence risks associated with consumers displaying behavioural responses. The service was not effectively managing five consumers’ physical, verbal and wandering behaviours and this deficiency is impacting their and other consumers’ life and personal and clinical care and services delivered. I have also considered clinical staff do not review strategies for effectiveness in a timely manner to manage consumers’ post behavioural incidents and one consumer’s risk of falls which resulted in several incidents.

For the reasons detailed above, I find, The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Standard 3 Requirement (3)(b).

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) under Standard 7 Human Resources. All other Requirements in Standard 7 were not assessed.

The Assessment Team were not satisfied the service demonstrated there is sufficient staff to provide safe and effective quality care and services to consumers and have recommended Requirement (3)(a) not met. I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the Approved Provider’s response and find the service Non-compliant with Requirement (3)(a). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

The Assessment Team found the service was unable to demonstrate the workforce is planned and the total number and range of skills meet consumers’ needs and delivers safe and quality care for all consumers. The Assessment Team provided the following information relevant to my finding:

* Consumers were displaying behavioural responses due to delays with meal service. Meals were not provided as per recommendations noted in the consumer’s care plan. Staff comments aligned with these observations.
* Although the service provides activities of interest for consumers it was observed that a lot were not participating. This aligned with representatives’ comments, one saying they appear bored.
* The lifestyle staff said they provide consumers with meaningful activities but care staff are too busy so they find their focus is supporting them rather than managing the activities of interest program.
* Staff were observed signing the consumer ‘sighting charts’ at the end of their shift for the entire shift. This aligned with staff comments.
* Other staff, including clinical and allied health professionals, said consumers’ needs are not adequately met due to staff shortages in the memory support unit.

The Approved Provider submitted a response to the Assessment Team’s report and asserts their commitment to meet their responsibilities as an Approved Provider and to address the deficiencies identified by the Assessment Team. The Approved Provider’s response includes a plan for continuous improvement to rectify the identified issues. The continuous improvement plan identified the actions related to this Requirement include meeting with the People and Culture team to identify strategies to reduce agency staff, engaging the Allied Health Professionals earlier to encourage consumers’ participation in the daily activities of interest and review the activities being offered, stagger personal breaks for staff to provide additional support during meal times, and appoint the new Clinical Adviser to provide clinical guidance and leadership to the team.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

I acknowledge the improvements noted by the Approved Provider and although they plan to address the leadership and supervision of staff, encourage consumers’ participation in daily activities of interest, and stagger staff breaks and reduce the engagement of agency staff, the plan does not clearly address the deficiencies noted by the Assessment Team. The Approved Provider has not identified how they plan to consider and manage the workforce numbers, the range of skills and how they plan to adapt these to respond to changing needs and situations to ensure the service meets consumers’ needs and delivers safe and quality care.

I acknowledge management use a financial benchmarking guide for aged care to determine the staffing levels and they believe the service is currently overstaffed. I find, however, at the time of the Assessment Contact, the service staffing levels and mix did not support effective monitoring/supervision of consumers or consider the consumers’ needs. I have relied upon observations made by the Assessment Team, noting consumers were left unsupervised for periods of time in common areas, consumers were not participating in activities of choice, consumers’ behavioural responses were not managed and consumer meals were delayed. In addition, these observations align with the feedback from staff and representatives.

For the reasons detailed above, I find, The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Standard 7 Requirement (3)(a).

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

## The Assessment Team assessed Requirement (3)(c) under Standard 8 Organisational governance. All other Requirements in this Standard were not assessment.

The Assessment Team have recommended Requirement (3)(c) not met. I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the Approved Provider’s response and find the service Non-compliant with Requirement (3)(c). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-compliant

*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.*

The Assessment Team found the service could demonstrate the organisation has finance governance systems implemented, however, they were unable to demonstrate effective governance for information management, continuous improvement processes, workforce, regulatory compliance or feedback and complaints systems. The Assessment Team provided the following information and evidence relevant to my finding:

* Information is not always available to staff and strategies to manage consumers’ needs, and/or recommendations from specialists are not documented in the care plan.
* The organisation has no continuous improvement systems to process, access, monitor and improve the quality and safety of care and services provided. This includes complaints and feedback mechanisms to drive care and service improvement.
* Although the organisation uses an aged care financial benchmarking guide to determine the workforce numbers, the guide does not consider the workforce planning to ensure the number and mix of workforce is planned to ensure the delivery and management of safe and quality care and services.
* Restraint processes are not aligned with legislative requirements, and the organisation does not have a consolidated log to monitor alleged or suspected assaults where the discretion was not to report.

The Approved Provider submitted a response to the Assessment Team’s report and asserts their commitment to meet their responsibilities as an Approved Provider and to address the deficiencies identified by the Assessment Team. The Approved Provider’s response includes a plan for continuous improvement and a staff training plan to rectify the identified issues. Actions related to this Requirement include:

* A primary care approach where staff will be assigned to consumers, and handover sheets will reflect this and note areas requiring particular attention during the shift. Decisions and actions to inform care delivery for the consumers will be discussed.
* The newly formed Clinical and Quality Governance Team will manage the service continuous improvement plan, oversee the service and manage the improvements.
* An audit will be managed to ensure all restraint and discretionary alleged or suspect physical assaults are recorded and align with best practice and legislative requirements and monitored to ensure ongoing compliance.
* Feedback and complaints will be recorded and monitored by the leadership group and actions implemented. This information will inform further training for staff to improve care and service delivery.

Although the Approved Provider has acknowledged the organisation uses benchmarking guides to determine staffing levels, the organisation has not provided any details on how they determine if the staff engaged have the skills and/or knowledge and clearly defined roles and accountability for managing consumers’ needs and ensure the delivery of safe and quality care.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

I acknowledge the service’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, I find at the time of the Assessment Contact, the service did not have effective governance systems relating to information management, regulatory compliance, workforce governance and feedback and complaints.

I have considered the evidence provided by the Assessment Team in the Non-compliant Requirements in this report which demonstrates deficiencies have not been identified by the organisation’s monitoring processes. In addition, although management could describe improvements they had implemented, the service did not have a continuous improvement plan to monitor and drive safe and quality care services.

For the reasons detailed above, I find, The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Standard 8 Requirement (3)(c).

# 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.

The service should seek to ensure the following:

Standard 3 Requirement (3)(a) and (3)(b)

* Consumers receive safe and quality care, which is tailored, based on an assessment of the needs goals and preferences to optimise their health and well-being, including staff actioning identified changes to needs.
* Effectively manage high impact or high prevalence risks associated with consumers’ care and service delivery to ensure their safety and the safety of others, including staff and consumers at the service.

Standard 7 Requirement (3)(a)

* Staffing levels and skill mix are appropriate and based on the needs of the current consumers at the service.
* Staff have the appropriate skills and knowledge required of their position, including implementing processes to monitor competency for specific roles.

Standard 8 Requirement (3)(c)

* Effective governance systems relating to information management, workforce governance and feedback and complaints.
* Monitor trends in reports and feedback and complaints processes to drive continuous improvement.