Howard Solomon Aged Care Facility

Performance Report

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**Commission ID:** 7250

**Provider name:** Grand Lodge of WA Freemasons Homes for the Aged (Inc)

**Assessment Contact - Site date:** 20 August 2020

**Date of Performance Report:** 23 December 2020

# 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 |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | 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; 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 Contact - Site report received 7 September 2020.

# STANDARD 3 NON-COMPLIANT Personal 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 Quality Standard is Non-Compliant as two of the seven specific Requirements in this Standard have been assessed as Non-Compliant.

The Assessment Team assessed Requirements (3)(a) and (3)(b) in this Standard, all other Requirements in this Standard were not assessed. An overall assessment of this Standard was not completed at this Assessment Contact.

The Assessment Team have recommended Requirements (3)(a) and (3)(b) in this Standard as not met. The Approved Provider submitted a response to the Assessment Team’s report.

Based on the Assessment Team’s report and the Approved Provider’s response I find the Grand Lodge of WA Freemasons Homes for the Aged (Inc), in relation to Howard Solomon Aged Care Facility, to be Non-Compliant with Requirements (3)(a) and (3)(b) in this Standard. I have provided reasons for my findings in the respective Requirements below.

### 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 that each consumer gets safe and effective personal and clinical care that is best practice. The Assessment Team provided the following findings and evidence relevant to my finding:

* One consumer, who was assessed as being at very high risk of pressure injuries, did not have their skin integrity or pain assessed, monitored or managed in accordance with best practice, following the identification of a change to the consumer’s skin integrity. The consumer was also observed by the Assessment Team to not be provided with effective pressure area care on the day of the Assessment Contact.
  + The consumer sustained a stage 1 pressure injury, however, the service did not conduct a reassessment or evaluation of the consumer’s skin, pain or associated care strategies following the development of the wound. The wound has deteriorated to a stage 2 pressure injury.
  + The consumer was not provided with specialised equipment or an evaluation/change to pressure area care strategies to support effective management of the pressure injury in a timely manner.
    - A referral for an air mattress was not initiated until two days after identifying the stage 1 pressure injury.
    - A directive for strict and increased pressure area care was not implemented until the day of the Assessment Contact.
  + No formal pain monitoring or pain assessment has occurred following two medical officer reviews which identified that the consumer had pain associated with the pressure injury area and changed the pain medication regime.
  + The Assessment Team observed the consumer looking uncomfortable and moaning on the day of the Assessment Contact. At the time of this observation, the consumer told the Assessment Team they felt sick and uncomfortable. The Assessment Team informed staff about the consumer requiring assistance on two occasions because the consumer was unable to access their call bell. However, the consumer was not assisted with repositioning in a timely manner. The Assessment Team observed the consumer to be in the same position one hour after initially alerting staff. The Assessment Team also observed the consumer in the same position two-and-a-half hours later.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings and recommendation. The Approved Provider provided the following information and evidence relevant to my finding:

In relation to the consumer with a current stage 2 pressure injury:

* The consumer has resided at the service for five years and has only sustained one other pressure injury, which healed in 25 days. In the context of the consumer’s comorbidities and refusal of care, this provides evidence that risk of pressure injury was being effectively managed.
* The consumer’s pressure area care strategies were reviewed with the wound management plan when the pressure area was first identified and the handover sheet update to include three to four-hourly pressure area care.
* The consumer spends a lot of time in their chair and the chair has been assessed by an occupational therapist as suitable for the consumer’s needs.
* An air mattress was not available due to COVID-19 but was implemented as soon as one was available.
* Pain was being monitored each shift and documented on the shift summary sheet and the resident liaison visited the consumer frequently and did not observe pain.

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

In relation to the consumer with a stage 2 pressure injury, I find that the service did not assess or manage the consumer’s skin or pain in accordance with best practice or provide care that is tailored to the consumer’s needs, or optimises the consumer’s health and well-being. While the Approved Provider asserts that the consumer’s skin and pressure area care strategies were reassessed as part of the wound management plan, the evidence provided in the response does not support that the consumer’s skin was assessed in accordance with best practice or that pressure area care strategies were reassessed or evaluated to ensure the most appropriate and effective strategies were identified and implemented.

* The Approved Provider submitted a handover sheet which shows that staff were directed that the consumer was to have pressure area care every three to four hours. However, this handover sheet did not indicate the date this directive was implemented. The consumer was known to be at ‘very high risk’ of pressure injury development prior to the identification of the stage 1 pressure injury and it is reasonable to expect that the service should have undertaken a skin and pressure area risk assessment at the time of the pressure injury identification. An assessment at this time would ensure consideration of the consumer’s current health status and present intrinsic and extrinsic factors associated with increased risk of pressure injury. Without effective assessment processes, the service cannot be assured the most effective pressure injury prevention strategies were implemented to ensure the stage 1 pressure injury did not deteriorate and that other pressure injuries did not develop.
* The Approved Provider asserts that the consumer often chose to sit out of bed in their chair which has been assessed as appropriate by an occupational therapist. However, this assessment was completed in March/April 2020 and was not completed considering the new pressure injury or the consumer’s current health status or reduced mobility at the time of the development of the pressure injury.

In coming to my finding, I have also considered that the consumer’s pressure injury deteriorated to a stage 2 pressure injury, and that the medical officer observed two pressure injuries on their review of the area almost three weeks after the stage 1 pressure injury was identified. Considering the service did not demonstrate pressure area care strategies were effectively reviewed or evaluated following the identification of the stage 1 pressure injury, this suggests the pressure area care strategies used for the consumer were not effective or in accordance with best practice.

While the Approved Provider asserts staff were monitoring the consumer’s pain during each shift, the evidence provided does not support pain was effectively monitored or was assessed following the identification of the stage 1 pressure injury, in accordance with best practice.

* The Approved Provider provided a shift summary to support monitoring of the consumer’s pain on each shift, however, in almost a three-week period there were only three notations related to the consumer’s pain. This included the period where a medical officer found the area near the pressure injury was swollen and painful to touch. The Approved Provider also suggested the resident liaison officer frequently visited the consumer who observed she was comfortable, however, the service did not provide evidence of regular monitoring based on clinical assessment.
* Additionally, the service did not commence a pain chart following a change in the consumer’s pain management regime by the medical officer to effectively monitor the efficacy of the new regime.

In coming to my finding, I have also considered that a stage 2 pressure injury can cause pain and the medical officer observation that the area near the pressure wound was painful, both instances should have reasonably initiated a formal pain monitoring process. This pain monitoring process should be consistent with best practice, that is, using an evidence-based assessment tool completed by appropriately trained staff, with consistent monitoring.

Furthermore, the Assessment Team’s observations of the consumer moaning and confirming they were uncomfortable without staff (who were aware of the consumer’s request to be repositioned) not attending to the consumer for at least one hour does not support that the consumer received care which optimised their health and well-being.

For the reasons detailed above I find the Grand Lodge of WA Freemasons Homes for the Aged (Inc), in relation to Howard Solomon Aged Care Facility, to be Non-Compliant with Standard 3 Requirement (3)(a).

### 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 did not effectively manage high impact or high prevalence risks associated with the care of each consumer, specifically in relation to managing known risks of pressure injury development, assessing, monitoring and review of risks associated with the use of physical restraint, and managing risks associated with reduced oral intake. The Assessment Team provided the following findings and evidence in relation to four different consumers which is relevant to my finding:

* One consumer who was assessed by the service as being at ‘very high risk’ of pressure injuries did not have three pressure injuries identified by staff until two wounds were classified as stage 2 pressure injuries and one wound was classified as an unstageable wound. The Assessment Team also observed that the consumer was not provided with pressure area care strategies as directed by the registered nurse following the identification of the pressure injuries.
* One consumer who was assessed by the service as being at ‘high risk’ of pressure injuries did not have a pressure injury identified until the wound was unstageable and the wound was identified two weeks later as having a blackened and necrotic appearance.
* One consumer who was identified with a stage 2 pressure injury, was also identified to have lost a significant weight loss and had changes in their food and fluid intake in the six-week period preceding the identification of the pressure injury. However, staff were unable to demonstrate they were adequately monitoring the consumer’s oral intake to ensure potential malnutrition risks were managed to support wound healing.
* A consumer’s care plan directs staff to use an ‘all-in-one’ suit at night time for the consumer but does not indicate the reason for using this device. Clinical management informed the Assessment Team the ‘all-in-one’ suit was worn only at night to maintain the consumer’s dignity relating to the consumer removing their continence aid at night. However, management have not considered or assessed the risks associated with the use of physical restraint.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings and recommendation. The Approved Provider provided the following information and evidence relevant to my finding:

In relation to the consumer with three pressure injuries:

* The consumer has resided at the service for the past five years with no prior incidents of pressure injuries which demonstrates the risk of pressure injury has been effectively minimised since the consumer’s entry to the service.
* The consumer prefers to sit in their chair rather than lay in bed.
* A personal care chart shows personal care staff were attending to the consumer’s personal hygiene prior to and after the day the pressure injuries were identified.
* The consumer was provided with a supplement to aid wound healing from the day the pressure injury wounds were identified.
* One wound has healed and the unstageable pressure injury has improved to a stage 2 pressure injury.

In relation to the consumer with an unstageable pressure injury:

* As part of the consumer’s pressure care regime staff were assisting the consumer to take at least four-hourly walks during the day and ensuring the consumer changed position overnight.
* Staff observed redness on the consumer’s heels several months before the unstageable wound was identified and foam booties were used which prevented further breakdown and subsided the redness.
* An air mattress was implemented due to the consumer spending more time in bed.

In relation to a consumer with a stage 2 pressure injury with decreased oral intake:

* The consumer had been reviewed by a dietitian and noted that the consumer’s weight remained significantly above the height/weight ratio. Also, the consumer suffers from congestive cardiac failure and was on medication to remove excess fluid, which the significant weight loss was attributed to.

In relation to the consumer who is dressed in an ‘all-in-one’ suit each night:

* Due to confusion, the consumer had been shredding their continence aids at night, which resulted in disturbed sleep. To optimise the consumer’s continence and dignity a decision was made to source an ‘all-in-one’ suit for night time use only and it has been effective in ensuring the consumer achieves a restful sleep.
* The service’s clinical audit system does not identify the ‘all-in-one’ suit as a physical restraint.
* The consumer’s next of kin was contacted on the day of the Assessment Contact to gain consent for the use of the ‘all-in-one’ suit.

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

In relation to the consumer with three pressure injuries, I find the service did not effectively manage the consumer’s identified very high risk of developing pressure injuries. The service had assessed the consumer as being at ‘very high risk’ of a pressure injury several months before the three pressure injuries were identified. However, staff did not effectively manage this risk because they did not identify changes to the consumer’s skin integrity until significant wounds were identified on the consumer’s sacrum. The Approved Provider asserts that staff were monitoring the consumer’s skin through daily provision of personal hygiene. However, I find it reasonable that staff should have been aware of the consumer’s acute risk of pressure injury and noticed signs of pressure injury development prior to the identification of two stage 2 and one unstageable pressure injury wounds considering staff were providing daily assistance with hygiene. Additionally, the Assessment Team observed the consumer to not have received pressure area care in accordance with clinical directives to minimise risk of further pressure injury development or wound deterioration.

In relation to the consumer with one unstageable pressure injury, I find the service did not effectively manage the consumer’s identified high risk of developing pressure injuries. I acknowledge that the Approved Provider asserts various pressure relieving equipment was used for the consumer prior to the development of the pressure injury. However, staff did not effectively manage the risk of pressure injury development because staff did not effectively monitor changes to the consumer’s skin integrity prior to a significant unstageable pressure injury being identified. The service states the pressure relieving air mattress was implemented, and staff were using foams booties after redness was identified on the consumer’s heels in a few months prior. The Approved Provider asserts that staff were monitoring the consumer’s skin through daily provision of personal hygiene, however, I find it reasonable that staff should have noticed signs of a pressure injury prior to the wound becoming unstageable, considering the consumer was at high risk of pressure injury development and the consumer was identified with reddened heels several months prior which resolved following the implementation of the booties. Additionally, the Approved Provider asserts staff conducted skin integrity checks daily when personal care is attended, however, this chart does not indicate staff identified changes to the consumer’s skin integrity prior to the identification of the unstageable pressure injury.

In relation to the consumer with a stage 2 pressure injury and significant weight loss, I find the service was aware of the consumer’s decreased oral intake and considering the identification of the stage 2 pressure injury, should have assessed the consumer’s oral intake more rigorously and ensure the consumer was not suffering from malnourishment. I acknowledge that the consumer was administered medication for a chronic heart condition with the desired effect to remove excess fluid, resulting in weight loss. However, progress notes indicate staff were aware of the consumer’s decreased oral intake and this should have prompted the use of a risk assessment to minimise risks associated with poor hydration and nutrition, especially in the context of the consumer having a significant pressure injury.

In relation to a consumer who is dressed in an ‘all-in-one’ suit each night, I find the service has not considered this device has restricted the consumer’s free movement and have subsequently failed to assess, monitor and review the use of the restraint, or gain informed consent, in accordance with the *Quality of Care Principles 2014* to ensure the restraint is used a last resort, is used safely and for the least amount of time possible. While I acknowledge the intent of the service in using the ‘all-in-one-suit’ is to support the consumer’s continence management and preserve the consumer’s dignity, this device does not allow the consumer to have free movement and requires the service to undertake several actions if using the device to comply with relevant legislation and to minimise risks associated with physically restraining consumers.

For the reasons detailed above I find the Grand Lodge of WA Freemasons Homes for the Aged (Inc), in relation to Howard Solomon Aged Care Facility, to be Non-Compliant with Standard 3 Requirement (3)(b).

# STANDARD 8 NON-COMPLIANT Organisational 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 Quality Standard is Non-Compliant as one of the five specific Requirements in this Standard has been assessed as Non-Compliant.

The Assessment Team assessed Requirements (3)(c) and (3)(d) in this Standard, all other Requirements in this Standard were not assessed. An overall assessment of this Standard was not completed at this Assessment Contact.

The Assessment Team have recommended Requirement (3)(c) in this Standard as met and (3)(d) in this Standard as not met. The Approved Provider submitted a response to the Assessment Team’s report.

Based on the Assessment Team’s report and the Approved Provider’s response I find the Grand Lodge of WA Freemasons Homes for the Aged (Inc), in relation to Howard Solomon Aged Care Facility, to be Compliant with Requirement (3)(c) and Non-Compliant with Requirement (3)(d) in this Standard. I have provided reasons for my findings in relation to Requirement (3)(d) below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) 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.*

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

*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.*

The Assessment Team found the service did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers. However, the Assessment Team did find the organisation has effective systems to identify and respond to abuse and neglect of consumers and to support consumers to live the best life they can. The Assessment Team provided the following findings and evidence relevant to my finding:

* Staff practices are not identifying changes to skin integrity in a timely manner for consumers identified at high or very high risk of developing a pressure injury.
  + Pressure injuries are only first being identified by staff at an advanced stage of pressure injury such as at stage 2 or unstageable.
* Staff practices did not adequately respond to potential risks associated with significant weight loss.
* Management and staff did not recognise the use of an ‘all-in-one’ suit to be a restrictive device which use is subject to be used in accordance with relevant legislation to ensure risks associated with physically restraining consumers are effectively identified, monitored and evaluated.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings and recommendation. The Approved Provider provided the following information and evidence relevant to my finding:

* The Approved Provider has submitted information and evidence in relation to Standard 3 Requirements (3)(a) and (3)(b) to support staff practices have effectively identified and managed risks associated with the care of each consumer.
* Clinical staff showed the Assessment Team the service’s external audit program which is designed to facilitate best practice care and accreditation. This audit program is used to record the numbers and types of restrictive practices and does not include the use of an ‘all-in-one’ dignity suit.
* Management informed the Assessment Team at the exit meeting that staff had consulted with the consumer’s next of kin in relation to use of the ‘all-in-one’ suit and obtained verbal consent for its use.

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

While the Approved Provider asserts that the consumers identified by the Assessment Team in Standard 3 Requirements (3)(b) have risks associated with their care identified and appropriately managed, my decision in relation to that Requirement includes that several staff practices have not effectively identified, and managed risks associated with pressure injuries, weight management and the use of restrictive devices. However, I do acknowledge that the service has developed a procedure for ‘identifying and responding to a deterioration in a resident health’ since the Assessment Contact.

Additionally, the Approved Provider asserts that their external audit program does not identify the use of an ‘all-in-one’ dignity suit as a restraint. However, I find based on the Assessment Team’s report, this suit is being used to restrict a consumer’s free movement, which brings inherent risks associated with its use. The *Quality of Care Principles 2014* outlines the processes required to be taken to support effective management of risks associated with the use of restrictive devices. I acknowledge the service contacted the representative of the consumer on the day of the Assessment Contact, however, this did not demonstrate the service has effectively assessed the risks associated with using this restraint device, effectively trialled other alternatives to ensure the restraint is used a last resort and did not demonstrate the representative provided informed consent.

For the reasons detailed above I find the Grand Lodge of WA Freemasons Homes for the Aged (Inc), in relation to Howard Solomon Aged Care Facility, to be Non-Compliant with Standard 8 Requirement (3)(d).

# 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.

* Ensure staff effectively provide pressure area care interventions and can identify and monitor changes to consumers’ skin integrity.
* Ensure staff are able to effectively monitor and identify pain experienced by consumers.
* Ensure effective review and assessment of consumers’ skin when initial changes to skin integrity are identified.
* Ensure staff monitor consumers’ oral intake when consumers have been identified as having decreased oral intake.
* Ensure devices used to physically restrain consumers are assessed, monitored and evaluated to identify and manage risks associated with the use of these devices.
* Ensure staff practices are consistent with the service’s policies and procedures.