Villa Del Sole

Report

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**Commission ID:** 3544

**Approved Provider name:** Securo Care Proprietary Limited

**Assessment Contact - Site date:** 16 February 2022 to 17 February 2022

**Date of Performance Report:** 25 March 2022

# Performance report prepared by

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# Publication of report

This Performance Report **will 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 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(c) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |

# Detailed assessment

This performance report details the Commissioner’s assessment of the Approved 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 Approved Provider’s response to the Assessment Contact - Site report received 07 March 2022

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team undertook a performance assessment to investigate complaints received by the Commission in relation to issues with the management of weight loss, infection prevention, inadequate laundry services, food quality and variety and inadequate activities. The focus of this performance assessment was to allow the service to demonstrate its level of compliance with the requirements reviewed under the Quality Standards.

The service was able to demonstrate that assessment and care planning was being completed to ensure safe and effective care and services were being delivered.

Care planning documents for consumers were reviewed regarding assessment and planning of care. These files contained comprehensive assessment and care planning information. Care files included medical and psychosocial considerations, consumer's goals, preferences and individualised interventions and included interventions to minimise risks to each consumer's health.

This includes consumers at risk of choking, consumers with a falls risk, those with skin integrity issues and consumers with diabetes. Risk assessments relating to chemical and physical restraint are in place and regularly reviewed every three months.

The one requirement assessed was found to be compliant.

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

# 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 Assessment Team identified that weight loss, the management of psychotropics and behaviour management were not always being effectively identified by the service, placing consumers at increased risk.

Only when consumers had a weight loss of over 2kgs in a month or consistent weight loss were they monitored or dietary interventions were undertaken.

The service did not accurately record all psychotropic medications which were identified by the service at the time of the assessment.

The services practice of behaviour management does not align with the behaviour management flow chart.

The service has a documented pain management flow chart to guide staff on identifying, assessing, and documenting pain. However, the service does not consistently demonstrate that pain is reviewed following the administration of pain-relieving medication.

The service identifies, and documents risk-related activities relating to consumers.

Consumers are monitored for wounds and compromised skin integrity daily. All consumers with wounds have this recorded on the service’s ongoing wound report and in each consumer care documentation.

The service has a documented falls management flow chart to guide and direct staff on what to do if a consumer has a fall.

The service has an infection control policy and framework, COVID-19 outbreak management plan and antimicrobial stewardship (AMS) plan. Antimicrobial medication prescribed is monitored, tracked and analysed monthly.

Two of 3 requirements assessed were found to be non-compliant.

A decision of non-compliant in one or more requirements results in a decision of Non-Compliant for the Quality Standard.

### Assessment of Standard 3 Requirements

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

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

Although the service has a weight-loss management policy, they were inconsistent with managing the weight loss of all consumers. A weight-loss identification spreadsheet was implemented by the newly recruited clinical care manager and they had commenced trending and analysis of possible causes for consumer weight loss. This spreadsheet was not visible to all staff at the time of the visit but was subsequently included on the service’s electronic care system.

For one consumer the cause was likely to be due to contracting COVID-19 and referred the consumer to a dietitian. There was no evidence the service implemented its weight loss management strategy for this consumer. The response by the Approved Provider in relation to this consumer included documentation that showed these strategies were only implemented at the request of the dietitian following their review, although the consumer was under their healthy weight range for over a month.

### Another consumer lost almost 8 kgs in 16 days where response by the Approved Provider outlined the probable cause was said to be due to an acute condition. The consumer weighed 76 kg on 05 January 2022 and on 14 January 2022 was referred to the hospital in the home for review. On 21 January 2022, the consumer weighed 68.4 kgs.

### In their response, Approved Provider supplied documentation relating to the referrals made to dietitians and progress note entries. This did not show evidence that strategies under their weight management policy were consistently applied such as weekly weighs, providing fortified foods and supplements.

32 of the 42 current consumers onsite are currently prescribed psychotropic medication. There were issues noted with the service’s psychotropic medication register and this was acknowledged by the service at the time of the assessment contact. The deficits included recording behavioural and psychological symptoms of dementia as a diagnosis in the register for medications prescribed. On the second day of the assessment contact, the service commenced using the Aged Care Quality and Safety Commission self-assessment tool for recording consumers receiving psychotropic medications. The Assessment Team observed the document and the consumer information is being populated.

Reviews have not been conducted for all consumers on psychotropic medications as required. Documentation did not always record the non-pharmacological interventions to be utilised prior to the administering of psychotropic medications.

In their response, the Approved Provider advised that a review of the psychotropic register has been included on their plan for continuous improvement and they intend to complete this by 31 March 2022. They also stated that reviews were not conducted due to the service being in lockdown, however many of the reviews were due to occur outside of the lockdown dates. They are aware of the need to reduce the number of consumers on psychotropics; however, they admit a lot of work is still needed in the area.

The Assessment Team were unable to access records relating to medications provided in the past in order to check the frequency of psychotropic medications being administered as only current medications records are in the system and it will require a request to the electronic system service Approved Provider to access these records.

The Approved Provider responded with the following in relation to medication management:

* Medication and drug charts are managed on our electronic medication administration and progress notes documentation system.  All currently prescribed medications are live and can be viewed with a click of a mouse.
* All inactive PRN and ceased medications can be accessed through medication reports.
* The registered nurse notifies the resident’s general practitioner about the effects of PRN medications.  The general practitioner reviews this and either continue the PRN medication or ceases the PRN medication.
* The RNs also evaluate PRN medications and consults with the residents NOK about the usage of PRN medications.  Each resident has a nursing care plan review every three months.
* All aspects of care including medications are reviewed and managed by the resident’s general practitioner and all staff delivering care to the resident.

The service’s practice of behaviour management does not align with their behaviour management flow chart. Clinical staff, care staff and lifestyle staff were not able to describe specific consumers’ strategies for managing behaviours as documented in the consumer’s care documentation. One consumer had interventions recommended by Dementia Services Australia (DSA) but these recommendations were not evidenced in the consumer’s progress notes.

The Approved Provider in their response stated the service is aware of the recommendations by DSA and will ensure staff are provided with training and education in relation to care of consumers with behavioural issues.

The service identifies, and documents risk-related activities. Management said risk identification and management is undertaken for all consumers on admission to the service and as required when there are changes. This information is captured in each consumer’s care documentation, both initial and ongoing.

The service has a documented pain management flow chart to guide staff on identifying, assessing, and documenting pain. However, the service does not consistently demonstrate that pain is reviewed following the administration of pain-relieving medication – both regular and as required (PRN), or when incidents such as falls occur.

The Approved Provider in their response provided evidence that pain was assessed after falls but in one instance it was not conducted as required and a mandatory RN meeting was held to discuss the falls management protocols. Pain is not assessed on a daily basis but if a resident is identified as having pain the service will commence pain charting and documenting the progress notes.

Based on the information provided I find the service is non-compliant with this requirement based on the inconsistencies identified with weight loss management and the management and documentation regarding psychotropic medications. I do note that the Approved Provider has acknowledged these inconsistencies and have commenced ensuring improvements in these areas are undertaken.

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

*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.*

The Assessment Team found that the identification of and response to changes in health status is not always recognised and responded to in a timely manner for consumers. The service does not have robust systems in place to identify and review these risks.

Further to the evidence in relation to consumers referred to in Requirement 3(3)(b) regarding the identification and management of weight loss the Assessment noted these two cases.

One consumer had a weight loss of 3.82 kgs over the period of August 2021 to February 2022 and weighed just under 39 kgs in January 2022. This consumer also has a diagnosis of diabetes and was refusing medications and food due to nausea and vomiting. This had an impact on their blood sugar levels. The Approved Provider responded by providing evidence in the form of progress notes and medical practitioners’ notes of the processes undertaken in relation to this consumer, but the consumer was not referred for follow up until December 2021 and the deterioration had been occurring since August 2021. The steps taken by the service following the referral to the GP were adequate but the response was not timely.

The Assessment team also noted another consumer tested positive for COVID-19 on 29 January 2022 and was managed within the service by ‘hospital in the home’ and also had a significant weight loss in January 2022. Clinical staff had informed the Assessment Team that it was not noted until 8 February 2022 when the service commenced weekly weighs of the consumer, but the consumer’s weight was checked on 5 February 2022. No other strategies appear to be implemented or referrals made to the dietician.

According to the Assessment Team, the weight report generated by the service does not reflect timely identification of the consumer’s deterioration in weight.

The response by the Approved Provider refuted this information advising that the consumer had been referred to a dietitian in November 2021 due to fluctuating weight and had been on weekly weighs and supplemented diet. They had also referred the consumer to the dietitian again on 4 February 2022. However, I note this was the day before the weight was checked and entered into the electronic system. The Approved Provider also advised that the consumer tested positive for COVID-19 which furthermore reduced their appetite.

According to the Assessment Team, the weight report generated by the service does not reflect timely identification of the consumer’s deterioration in weight.

The service's weight loss management flow chart (including referral to a dietitian and general practitioner) is commenced if there is a greater than two-kilogram weight loss within a month, however, this is not enough to capture all deterioration as a loss of 2 kgs may have differing levels of impact on different consumers.

Based on the information I find the service non-compliant in this requirement.

### 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 4 Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team undertook a performance assessment to investigate complaints received by the Commission in relation to issues with the management of weight loss, infection prevention, inadequate laundry services, food quality and variety and inadequate activities. The focus of this performance assessment was to allow the service to demonstrate its level of compliance with the requirements reviewed under the Quality Standards.

The service supports consumers in participating in activities both within the service and externally. Consumers said they are able to be involved in activities of interest to them and are supported to maintain their chosen relationships. Electronic care planning documents contain information about consumers' interests and staff demonstrated knowledge of individual consumer preferences.

Representatives stated the service supported the consumers to remain connected with family and social connections during the period of COVID-19 lockdown by use of telephone and video calls. During this time families were also able to visit consumers who struggled with behavioural issues, were depressed or to provide end-of-life care.

Consumers are encouraged to participate in activities but those who do not wish to participate in group activities, are provided one on one activities with lifestyle staff on a daily basis.

The Assessment Team noted there were not enough activities for consumers with impairments that prevent them from joining in on regular group activities.

The one requirement assessed was found overall to be compliant.

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

# 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 Assessment Team undertook a performance assessment to investigate complaints received by the Commission in relation to issues with the management of weight loss, infection prevention, inadequate laundry services, food quality and variety and inadequate activities. The focus of this performance assessment was to allow the service to demonstrate its level of compliance with the requirements reviewed under the Quality Standards.

The service was unable to demonstrate how high-risk, high-prevalent risk was identified and managed at the service. The service’s three main high risks, high prevalent areas are identified as falls management, nutrition and hydration and medication management.

The service was not able to show how they manage and minimise the use of psychotropic medication. The service was unable to demonstrate to the Assessment Team how they monitor psychotropic medication usage and could not generate reports on medication usage per consumer.

A spreadsheet showing the weight loss of consumers was only visible to the clinical care manager and not clinical staff or management. The information contained in the report would be used to generate a dietitian review.

The service is run by the Chief Executive Officer (CEO) and a team of executive members; weekly meetings are held between the facility manager and CEO to discuss progress, incidents and all areas of concerns and continuous improvement activities.

Management demonstrated the service provides mandatory education to staff on elder abuse, neglect, incident, compulsory and SIRS reporting, which is monitored. Staff could demonstrate an understanding of elder abuse and what they would do if they saw anyone treating a consumer inappropriately.

Staff and management described how all consumers are supported to express their preferences regarding how they wish to live their lives. This includes the risks they wish to take and how these are managed to ensure their safety.

The one requirement assessed was found overall to be non-compliant.

A decision of Non-compliant in one or more requirements results in a decision of Non-Compliant for the Quality Standard.

## Assessment of Standard 8 Requirements

### 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*
4. *managing and preventing incidents, including the use of an incident management system.*

Clinical management reported that their electronic system cannot display the frequency of as-needed medications that have been administered on the medication charts. Clinical staff explained to the Assessment Team that once the general practitioner does a review of the medication chart the information related to the previous administration of a medication is no longer accessible to the service. To determine if a medication has been administered it must be written into the progress notes. It is therefore unclear how staff monitor and reports side effects on medication provided, including regular regimen medication or as-needed medication.

It is unclear how clinical staff monitor psychotropic medication it identifies as a possible chemical restraint. The service has commenced using a spreadsheet based on the Commission’s guidelines and the capture of data is in progress. The service acknowledges the use of psychotropics is high with 32 of the 42 current residents prescribed psychotropics. They are working to minimise the usage but acknowledge it is a work in progress.

Based on discussions with management and staff, the service Approved Provider of the care planning system needs to be contacted to generate medication reports with historical usage. The service was unable to effectively demonstrate how medication reviews are undertaken three-monthly without having access to consumers’ historical medication regimens.

There were also issues with the identification and management of consumers at risk of weight loss. The only information being captured was with the clinical care coordinator who maintained her own spreadsheet to determine when a consumer required a dietitian review. This was added to the shared drive during the visit by the Assessment Team so that all clinical staff had access to the information.

The Approved Provider in their response outlined the following in relation to the management of medication:

* The clinical care coordinator and the registered nurse liaise with and are guided by general practitioners and the pharmacist.  Routine medication reviews are carried out by a service Approved Provider and reports are followed up by general practitioners. The local contracted pharmacy sends monthly psychotropic reports which are cross-checked with the register to ensure currency.  A list of psychotropic medications and a list of approved diagnoses are in place at the nurse’s station in the general practitioner’s folder for registered nurses and general practitioner’s reference. This was generated and provided by the pharmacist based on the Aged Care Quality and Safety Commission guidelines for psychotropic medication use.
* After the administration of medications all side effects are reported through the electronic system which the resident’s general practitioners can access.  When the general practitioners are not present at the service, they are able to access all documentation through the electronic system and reports related to their residents in addition to any concerns communicated to the general practitioners via the telephone, email and the general practitioner’s communication folder. All residents have a comprehensive nursing evaluation every three months and any changes are documented and communicated to the resident, the next of kin, and the resident’s general practitioners.
* Information related to the residents’ expired medications are not actively available on the residents’ current drug chart because the electronic system only displays residents’ current medications to minimise and prevent medication errors. The information regarding expired/inactive medications can be retrieved if necessary, from the electronic system’s reports section. We use this data to review and evaluate the effects of all medication including PRN usage. All past prescriptions/inactive medications (data) are in the electronic system and are always available for retrieval.

The service was unable at the time of the visit to show that weight loss was being managed effectively and also how they manage and work to actively reduce the use of psychotropics, which is acknowledged by the Approved Provider as being a work in progress. There have been improvements made including the appointment of a clinical care manager.

The response by the Approved Provider outlines ways they are now managing medications including the usage and administration of psychotropics. However, it does not appear to be fully embedded in their processes at the time of the assessment as clinical staff were unable to advise how a consumer’s medication history is available in the electronic system.

Based on the information I find the service non-compliant in this requirement but acknowledge the improvements they have recently made

# 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 all weight loss is identified in a timely manner and referrals made as required.
* Ensure there is consistency with the process where weight loss is identified and all measures are put in place including weekly weighs, increasing nutrition and fluid intake.
* Ensure psychotropic medication is recorded correctly and the usage is reviewed regularly with a view to reducing the amount prescribed and administered.
* Ensure all clinical staff are aware of how to review and manage medication in the electronic system.