Wynwood Nursing Home

Performance Report

77 Sydenham Road
NORWOOD SA 5067
Phone number: 08 8362 3568

**Commission ID:** 6865

**Provider name:** Wynwood Nursing Home Pty Ltd

**Assessment Contact - Site date:** 9 July 2020

**Date of Performance Report:** 21 August 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

|  |  |
| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(c) | 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 consumers, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 31 July 2020.

# STANDARD 2 NON-COMPLIANTOngoing 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 Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(e) in relation to Standard 2. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(e) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted 7 January 2020 to 9 January 2020.

The Assessment Team assessed Requirement 3(a) in relation to Standard 2. At the Site Audit, the Decision Maker found behaviour assessments and care plans were not effective to provide information to deliver safe and effective care to consumers. Whilst the service has made some improvements in response to the Non-compliance identified at the Site Audit, the Assessment Team were not satisfied the service’s processes in relation to behaviour charting and assessment were being consistently applied. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 2 Requirement (3)(a) and find the service does not comply with Requirement (3)(a). I have provided reasons for my decision in the specific Requirement.

At a Site Audit, in relation to Standard 2 Requirement (3)(e), the Decision Maker found whilst three consumers had a care review, care plans were not updated to meet the consumers’ current needs. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 2 Requirement (3)(e) and find the service does comply with Requirement (3)(e). I have provided reasons for my decision in the specific Requirement.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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.*

The organisation has processes for assessment and planning to inform the delivery of safe and effective care and services. However, for two consumer files viewed, the Assessment Team were not satisfied the service’s processes in relation to behaviour charting and assessment were being consistently applied. The Assessment Team identified inconsistences throughout behaviour assessment and evaluation documentation viewed. This was evidenced by the following:

* Two types of behaviour charts/assessments were being used in conjunction with each other. This included a new behaviour assessment and a version which included a numerical coding system.
* Information documented on behaviour charting completed by clinical staff was not consistent with information documented on charting completed by care staff for the same dates and times.
* New charts included generic comments relating to cause of behaviours. For example, five of six entries between 1 and 4 July 2020 for one consumer list ‘memory loss’ and ‘depression’ as the cause.
* New charts included generic comments relating to actions take to minimise behaviours. For example, five of six entries between 1 and 4 July 2020 for one consumer list ‘lots of reassurance and distract attention’ as actions taken.
* Behaviour evaluation documentation did not consistently reflect behaviours identified on behaviour charts. For example, three behaviours were documented in the evaluation for one consumer. However, these behaviours had not been identified on either chart as occurring during the assessment period.
* Behaviour evaluation documentation did not consistently reflect triggers identified on behaviour charts. For example, three triggers for behaviours were documented in the evaluation for one consumer. However, these triggers had not been identified on either chart as a trigger during the assessment period.

The approved provider’s response indicated they did not agree with the Assessment Team’s findings relating to inconsistencies in behaviour charting and assessment. However, the approved provider’s response demonstrates the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and have implemented or plan to implement the following actions:

* Reviewed the new behaviour assessment form to ensure capture of triggers, contributing factors, interventions and actions taken.
* Reinforcement of the correct use of the form through:
* Development of Guideline documents
* Inclusion of the behaviour form in the nurse orientation process for new staff
* Gathering feedback from staff in relation to the revised chart through meeting forums
* Staff notification of commencement of the new chart through memoranda
* One on one training with staff in relation to behaviour management, evaluation, documentation, assessment and review.
* A focus on staff training in use of behaviour charts, assessments and evaluation documents. This is being undertaken through training sessions, meeting forums and focus meetings.
* Establishing a Behaviour Advisory Committee to assist with improvements relating to behaviour management documentation and upskilling of staff.
* An external consultant, with experience in behaviour management and documentation, has been appointed.

While I acknowledge the approved provider’s proactive response to the Assessment Team’s findings, I find that at the time of the Assessment Contact the service’s behaviour assessment and evaluation processes were not being consistently applied. Two different behaviour charts were being used in conjunction with each other; both containing different information relating to behaviours being exhibited. Statements documented on behaviour charts relating to the cause of behaviours and actions taken were generic and consistently used for each behaviour documented. Additionally, behaviour evaluation documents did not consistently reflect behaviours or triggers which had been documented as occurring through behaviour charting processes.

For the reasons detailed above, I find the approved provider, in relation to Wynwood Nursing Home, does not comply with Requirement (3)(a) in Standard 2.

### Requirement 2(3)(e) Compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since Site Audit, including:

* A Care plan review checklist has been implemented. The checklist has been designed to notify staff when three monthly care plan reviews are due. Furthermore, additional steps to be completed during the reassessment process have been included, for example:
* Review of risk profiles and restraint authorisations, including required signatures
* Review of medication charts
* Review of palliative care forms
* Ensuring currency of assessments and evaluations
* Ensuring risk acceptance forms are in place, up to date and signed.
* Guidelines for three monthly care reviews have been created and were implemented in January 2020. The guidelines outline steps for staff to complete during the review process.
* The Assessment and planning policy was reviewed in July 2020.

In relation to Standard 2 Requirement (3)(e), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives confirmed staff consult with them during care plan review processes. Additionally, they confirmed they are required to view the care plan and sign relevant documentation.
* A sample of consumer care files viewed demonstrated care plans had been reviewed in line with the service’s process. Additionally, information reflected each consumer’s needs, goals and preferences.
* Staff interviewed confirmed implementation of the documents to assist them with care plan review processes. Staff stated the processes for review have been reinforced through meeting forums.

The organisation has monitoring processes in relation to Standard 2 Requirement (3)(e) to ensure care and services are regularly reviewed for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer.

For the reasons detailed above, I find the approved provider, in relation to Wynwood Nursing Home, does comply with Requirement (3)(e) in Standard 2.

# STANDARD 8 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 Quality Standard is assessed as Compliant as one of the five specific Requirements has been assessed as Compliant. The Assessment Team assessed Requirement (3)(c) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 7 January 2020 to 9 January 2020.

The Assessment Team assessed Requirement 3(c) in relation to Standard 8. The Assessment Team were not satisfied the service’s consolidated records for allegations of abuse were being maintained in line with legislative requirements. The Assessment Team have recommended Requirement 3(c) is not met. I have come to a different view from the Assessment Team’s recommendation and find the service does comply with Requirement (3)(c). I have provided reasons for my decision in the specific Requirement.

At a Site Audit, in relation to Standard 8 Requirement (3)(c), the Decision Maker found information management systems and processes were not effective to give appropriate members of the workforce access to information that is clear and helps them in their roles. This included medical directives not containing clear instructions for staff and not always recorded in relation to blood pressure monitoring and blood glucose levels, medication charts not being signed by Medical officers, care plans not containing current information relating to medical directives and a complaint not being logged onto the complaints register to assist the service to identify new or emerging trends. In relation to Requirement (3)(c), the service has implemented a range of actions to address the deficiencies identified which I have detailed 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.*

The organisation demonstrated processes in place relating to effective organisation wide governance systems, including continuous improvement, financial governance, workforce governance, and feedback and complaints. However, the Assessment Team were not satisfied the service’s processes in relation to maintaining a consolidated record of allegations of alleged abuse are managed in line with legislative requirements. This was evidenced by the following:

* Two incidents of consumer to consumer aggression had not been documented on the service’s consolidated log. In both instances, the service used their discretion not to report due the consumers’ diagnoses.
* Staff said they thought they had ensured all incidents had been entered into the log.

The approved provider did not agree with the Assessment Team’s findings. The approved provider’s response stated all logs are maintained electronically; a copy of the Reportable assault register was provided which included the incidents outlined in the Assessment Team’s report. Additionally, the approved provider’s response indicates the service was not asked by the Assessment Team to present the Reportable assault log.

The Assessment Team’s report clearly indicates consolidated records for allegations of abuse were viewed by the Assessment Team. Whilst these incidents had not been recorded on the log, there is no indication in the Assessment Team’s report that these incidents had not been managed in line with legislative requirements.

The Assessment Team’s report included evidence of actions taken to address deficiencies identified at the Site Audit conducted 7 January 2020 to 9 January 2020, including:

* A Care plan review checklist has been implemented. Additional steps to be completed during the three-monthly reassessment process have been included, such as:
* Reviewing medication charts to ensure they are signed by the medical officer and include stop dates for medications, where required.
* Review of each assessment/evaluation domain to ensure information is correct and current.
* Guidelines for three monthly care reviews have been created and were implemented in January 2020. The guidelines outline steps for staff to complete during the review process, including:
* Review of medication charts for regular and ‘as required’ medication orders to ensure there are no risks,
* Review of antibiotic usage and reporting to the Medical officer for further investigation if frequent antibiotic use is identified.
* Review of directives for monitoring of clinical observations, including blood pressure, weights and blood glucose levels to ensure directives are clear and in line with medication chart orders.
* Staff education provided in relation to proactive use of the complaint and feedback forms.
* A revised audit system has been implemented.

Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. I acknowledge the Assessment Team’s report indicates two incidents had not been documented on the consolidated log for allegations of assault. However, the Assessment Team’s report does not indicate these incidents had not been managed in line with legislative requirements. Additionally, the Reportable assault register was provided as part of the approved provider’s response and demonstrates these incidents have now been recorded.

* For the reasons detailed above, I find the approved provider, in relation to Wynwood Nursing Home, does comply with Requirement (3)(c) in Standard 8.

# 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.

Standard 2 Requirement (3)(a):

* Ensure staff have the skills and knowledge to:
* Complete behaviour charting and assessments reflective of triggers for identified behaviours and individualised management strategies implemented to minimise the incidence of behaviour.
* Analyse behaviour charting/assessment information to ensure evaluation documentation is accurate and reflective of the charting/assessment information gathered.
* Develop care plans which include individualised behaviour triggers and management strategies reflective of information gathered through charting/assessment processes.
	+ Review processes and practices relating to monitoring of behaviour management processes, including completion of charting/assessments, evaluation and review.
* Ensure policies, procedures and guidelines in relation to behaviour assessment, evaluation, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to behaviour assessment, evaluation, care planning and review.