Performance

Report

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| Name of service: | Aegis Parkview |
| Service address: | 6 Drummond Street REDCLIFFE WA 6104 |
| Commission ID: | 7307 |
| Approved provider: | Lakeside Hostel Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 10 November 2022 |
| Performance report date: | 19 December 2022 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Aegis Parkview (**the service**) has been prepared by J Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the Assessment Team’s report received on 14 December 2022; and
* the performance report dated 14 October 2021 for the Assessment Contact – Site undertaken on 9 September 2021.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |

A detailed assessment is provided later in this report for each assessed Standard.

# 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 have the skills and knowledge to:
  + Understand risks associated with consumers’ care and implement effective preventative strategies.
  + Provide appropriate care relating to behaviour management and medication administration.
  + Identify changes to consumers’ personal and clinical care needs and implement appropriate monitoring processes.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

Findings

Requirement (3)(b) was found non-compliant following an Assessment Contact undertaken on 14 October 2021, as the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to falls, restraint and swallowing.

The Assessment Team’s report for the Assessment Contact conducted on 10 November 2022 provided evidence of actions taken to address deficiencies identified, including, but not limited to, staff education and training.

The Assessment Team was not satisfied these improvements were effective, as evidence collected through interviews and documentation showed risks associated with the use of chemical restraint for one consumer had not been effectively managed. For example:

* The consumer was exhibiting agitation and aggression during early July 2022, and was prescribed Haloperidol and Quetiapine to manage their behaviours. There was no evidence demonstrating the effects of this newly commenced medication was monitored, as required under the organisation’s policy.
* Documentation showed the consumer experienced 13 falls and a 26.81kg weight loss, and developed an unstageable pressure injury of their heel between July to November 2022. These falls resulted in the consumer sustaining six skin tears and one dislocated finger. Documentation showed the consumer’s pressure injury has since healed.
* During November 2022, the consumer commenced on food and fluid intake charting, was reviewed by a Dietitian, and commenced supplements. The consumer was also reviewed by a Medical officer who requested cessation of a diuretic and Haloperidol.
* There was no evidence indicating the service considered chemical restraint as a contributing factor for the consumer’s falls, pressure injury or weight loss.
* Progress notes during October 2022 state the consumer is to be reviewed, as their representative identified they have oral thrush, and medication commenced the following day. There was no evidence indicating this was identified by the service.
* The representative provided the following feedback:
  + They noticed the consumer’s weight loss in September 2022 and were concerned about their oral intake, as they were often ‘zonked’ and difficult to rouse during mealtimes.
  + The consumer appeared thirsty and would quickly drink almost 600mls of water when they provided it to them.
  + They notified the service of their concerns and were informed the consumer has not lost weight and oral intake charting would commence.
  + They were concerned about the number of falls the consumer had experienced, and believe they physically declined following one fall in September 2022.
  + The service did not identify thrush in the consumer’s mouth.
  + They were aware the consumer was being administered psychotropic medication, however, had not signed consent or had risks explained to them.
* Two staff said the consumer started to have reduced oral intake when they were no longer able to feed themselves, and they would refuse to eat and spit out food. The staff said behaviour management strategies described in the consumer’s care plan are no longer effective.
* Management provided the following feedback:
  + They have added regular reviews of chemical restraint and Behaviour support plans to the organisation’s Continuous improvement activity. Medications had been discussed with the representative; however, consent had not been completed.
  + Falls investigations were not always completed to the expected standard.
  + Following reporting of concerns in September 2022 by the representative in relation to the consumer’s weight loss, a three-day intake chart was commenced, and the weight chart was reviewed. No weight loss or concerns were identified.
  + The consumer’s diuretic and Haloperidol was ceased following identification of weight loss. Other than for weight loss, management was unable to explain if the medication was ceased due to excessive drowsiness impacting on the consumer’s oral intake or whether it was a contributing factor towards pressure injuries or falls.

The provider did not disagree with the Assessment Team’s findings. The provider’s response included evidence of actions taken to address deficits documented in the Assessment Team’s report, which include, but are not limited to, increasing clinical staffing hours, staff education and training, and reviewing all consumers subject to restrictive practices. In relation to the named consumer, referrals to a Dietitian, Physiotherapist, Older adult mental health and Allied health have been completed, medication has been reviewed, strategies have been implemented in relation to the identified risk, and ongoing monitoring is occurring. I acknowledge actions taken by the provider to rectify issues identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Assessment Contact, high impact or high prevalence risks associated with each consumer had not been effectively managed.

I have considered that one consumer was prescribed chemical restraint to manage their behaviours, however, informed consent had not been obtained and the risks associated with the use of the restraint had not been identified and/or managed. I have considered that monitoring did not occur to identify effects of the medication, in line with the organisation’s policy, and despite the consumer experiencing falls and weight loss and developing an unstageable pressure wound, the service had not considered that it may be as a result of chemical restraint.

I have considered the service has been responsive to risks associated with the consumer, such as oral thrush, pressure injuries and weight loss, however, the service has not been proactive in identifying and preventing the risks. In relation to the consumer’s oral thrush, this was identified by the representative and not by staff who attend to the consumer’s daily oral care. The consumer’s pressure injury has healed, however, was not identified until it had deteriorated to stage two. Despite concerns raised by the representative, the consumer’s weight loss was not identified until it had dropped by 26.81kg.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)