Performance

Report

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| Name: | Aegis Stirling |
| Commission ID: | 7277 |
| Address: | 32 Spencer Avenue, YOKINE, Western Australia, 6060 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 9 May 2024 |
| Performance report date: | 21 June 2024 |
| Service included in this assessment: | Provider: 1466 Aegis Aged Care Group Pty Ltd  Service: 5727 Aegis Stirling |

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**This performance report**

This performance report for Aegis Stirling (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner).

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.

# Material relied on

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

* the assessment team’s report for the assessment contact (performance assessment) – site, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* the provider’s response to the assessment team’s report received 28 May 2024. The response includes commentary relating to the deficits identified in the assessment team’s report, as well as supporting documentation.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements were assessed. |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Other relevant matters:

* The assessment team initially entered the service to undertake a food, dining and nutrition monitoring visit. However, in response to deficits identified, the visit was changed to an assessment of performance, focussing on requirement (3)(b) in Standard 3 Personal care and clinical care.

# 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. | Compliant |

Findings

The assessment team recommended requirement (3)(b) not met as high impact or high prevalence risks, specifically risks of choking due to swallowing difficulties, were not effectively managed for each consumer. The assessment team’s report highlighted three consumers.

A consumer (Consumer A) was observed to struggle with eating and swallowing which was not managed effectively to mitigate risks of choking/aspirating. A dysphagia screen used by staff to downgrade the consumer’s diet modification level was not accurately completed or followed up by the service in line with the organisation’s dysphagia pathway, and the kitchen dietary list did not align with the consumer’s recorded abilities or the staff member’s recommended food texture. Documentation shows the consumer is at risk of aspiration/choking, with the last speech pathologist review occurring in 2022. Management and clinical staff said they follow the dysphagia flowchart procedure for assessment of dysphagia which states registered nurses complete the dysphagia screen and can downgrade a consumer’s texture-modified food and thickened fluids, due to signs of dysphagia, without a referral to a speech pathologist. Speech pathologists only receive referrals when the service seeks to upgrade consumers to a less modified food or fluid. However, the consumer was not referred to a speech pathologist in line with the organisation’s dysphagia pathway and the dysphagia screening score.

The dysphagia screen used by staff to downgrade a consumer’s (Consumer B) diet modification level was not completed accurately or followed up by the service in line with the organisation’s dysphagia pathway. The consumer has predisposing factors for potential dysphagia. Two dysphagia screens completed by staff indicated the consumer required a soft diet, however, there is no soft diet consistency in the organisation’s implemented framework, the international dysphagia diet standardised initiative (IDDSI). The IDDSI framework is not referred to in the dysphagia screen, therefore, it is not clear what this consistency should be. The initial dysphagia screen was undertaken in January 2024 and an IDDSI level 6 diet was recommended, however, this was not updated in progress notes and family were not informed until a week later. A further dysphagia screen in May 2024 recommended a diet downgrade to an IDDSI level 5 minced moist diet. However, kitchen handover sheets had not been updated and the consumer was still being provided with an IDDSI level 6 diet, which was confirmed by staff. Despite the outcomes of the two dysphagia screens, the consumer was not referred to a speech pathologist in line with the organisation’s dysphagia pathway and determined dysphagia screening scores.

A consumer (Consumer C) was assessed in January 2024 by a speech pathologist as they wanted to consume a different diet consistency to the one they had been receiving. The speech pathologist advised safe swallow strategies were to be used and the consumer’s preference was for supervision throughout the meal for safe swallowing. While a dignity of risk form was co-signed by the representative, management and the general practitioner, the speech pathologist was not involved in the process. The dignity of risk form includes potential outcomes, but no risk mitigation factors have been put in place to minimise the risk to the consumer other than they should be monitored while eating and drinking. The consumer was observed eating alone in their room with the door closed, with no supervision. The consumer said they requested the call bell be placed across their lap to alert staff if they have difficulties eating, and said there have been a number of occasions where the bell has not been placed on their lap and they have felt panicked. In response to the deficits identified, management issued a continuous improvement action relating to involvement of a speech pathologist in the discussion of mitigating risks with the consumer.

The assessment team also identified dietary forms for at least four consumers did not have food texture level information recorded which was found to result from an issue with the electronic assessment. While training records show staff attend regular texture-modified food and fluids (dysphagia) training, staff in one area of the service could not accurately explain IDDSI levels. Dry sponge cake was served to consumers on IDDSI level 6 diets which is not in line with the requirements; thickened fluids were not consistently prepared to IDDSI requirements; and gravy was not thickened to the levels required by IDDSI requirements for consumers on thickened fluids. In response, management issued a continuous improvement action to review the service’s practices and to provide additional education to kitchen and care staff.

I acknowledge the evidence brought forward by the assessment team. However, I have come to a different finding to the assessment team’s recommendation of not met and find this requirement compliant. In coming to my finding, I have placed weight on the provider’s comprehensive response to the assessment team’s report. The provider did not agree with all aspects of the assessment team’s report and included commentary in their response which directly relates to the deficits identified, as well as supporting documentation.

In relation to Consumer A, the provider’s response indicates the registered nurse supervising meal service was attending to another consumer. The registered nurse stated at no time was the consumer choking and care staff were supervising and attending to the consumer when they regurgitated their food. In response to the assessment team’s findings on the day of the assessment contact, management issued a number of continuous improvement actions, including education and monitoring to all registered nurses required to supervise the dining rooms, and completion of a serious incident response scheme (SIRS) report under the category of neglect. The provider acknowledges the consumer was not referred to a speech pathologist in line with the organisation’s process when their diet consistency was downgraded and the provider’s response includes evidence demonstrating this issue, as well as failing to escalate the consumer’s decline in ability to chew, is currently being addressed with the staff member involved. Additionally, the provider acknowledges registered nurses did not follow the dysphagia flowchart, and in response, education has been provided to registered nurses. Subsequent to the assessment contact, the consumer has been reviewed by the speech pathologist with the diet consistency remaining unchanged. The consumer’s representative has been notified of the review.

Subsequent to the assessment contact, Consumer B has been referred to a speech pathologist, with a review pending, and the provider notes the consumer has not experienced any choking episodes. The provider acknowledges that in response to the dysphagia screen findings, the registered nurse did not escalate their findings or refer this to clinical management, and this is currently being addressed with the staff member involved. Subsequent to the assessment contact, the provider has submitted a SIRS report in response. The speech pathologist has presented training and education to staff on IDDSI and dysphagia, with toolbox sessions on these topics being delivered by clinical management to staff on an ongoing basis during the handover process. A review of consumers on textured modified diets has been completed against meal order forms to ensure all dietary levels are detailed on the care plan, and education has been provided to staff in relation to accurate documentation.

In relation to Consumer C, progress notes included in the provider’s response show a comprehensive assessment of the consumer was undertaken by the speech pathologist, recognising the consumer’s request to consume a different diet consistency which would potentially place them at risk. This risk is outlined in the speech pathologist’s progress notes, noting a risk form will need to be completed for the desired diet consistency. This demonstrates that while the speech pathologist did not sign the dignity of risk form, they had been engaged to assess the consumer and their input and expertise was sought. I do, however, note that strategies to mitigate the risk are not included on the dignity of risk form, and the provider’s response indicates this form is currently under review by the speech pathologist. I also note that recommendations made by the speech pathologist to ensure the consumer’s safety during meal time activities are directly quoted on the related care plan used by staff to guide delivery of care. While I agree the consumer was not sufficiently supervised during meal time on the day of assessment contact, there is no further evidence to suggest that this occurs regularly or that there have been any related incidents as a result. The provider has implemented a chart to ensure the consumer has their call bell at meal times.

The provider’s response also outlines actions taken subsequent to the assessment contact to address some of the deficits identified, including undertaking a full review of all consumers with swallowing deficits and/or receiving a textured modified diet, with consumers referred to speech pathology for further assessment, where identified; creation of a message board for registered nurses to remind them to follow the dysphagia flowchart; posting of an organisational announcement in relation to timely escalation to speech pathology and process; and providing education to all kitchen staff relating to IDDSI, mash potato and gravy mix. The provider’s response includes continuous improvement plans, either initiated on the day of or subsequent to the assessment contact, addressing the deficits identified by the assessment team. I would encourage the provider to continue to progress with these improvement initiatives and to ensure actions implemented are monitored for effectiveness.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care complaint.