Performance

Report

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| Name of service: | Ashleigh House Hostel |
| Service address: | 20-24 Bergen Crescent SALE VIC 3850 |
| Commission ID: | 3026 |
| Approved provider: | Sale Elderly Citizens Village Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 November 2022 to 16 November 2022 |
| Performance report date: | 13 January 2023 |

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 Ashleigh House Hostel (**the service**) has been prepared by D. Fekonja, 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 6 December 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **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.

2(3)(e)

* Ensure that care and services are reviewed following changes in consumer health and following incidents.
* Ensure falls management processes are followed consistently.

3(3)(a)

* Ensure pain is documented accurately in care plans and strategies and interventions to manage pain are individualised for each consumer.

3(3)(b)

* Ensure that consumers with responsive behaviours have comprehensive behaviour support plans that guide staff in how to manage care and prevent incidents.
* Ensure falls processes are followed consistently with neurological observations taken consistently.
* Ensure up to date medical directives are in place to guide staff in relation to diabetes management.

8(3)(d)

* Ensure incidents that involve psychological and emotional abuse including threatening actions and verbal threats are reported as required.
* Ensure all incidents are investigated and with root cause analysis performed to prevent recurrence and ensure the safety of all consumers.
* Ensure that behaviour and care plans include detailed strategies to manage behaviours and prevent incidents from occurring.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(e) | 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. | Non-compliant |

Findings

**Requirement 2(3)(a)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate that assessment and planning adequately considered risks to consumers or informed the delivery of safe and effective care and services, specifically in relation to psychotropic medications, pain management and medications.

Following a site assessment in November 2022, Assessment Team found that the service did not demonstrate evidence of improvement in relation to the consideration of risk. Assessments were not completed in a timely manner to identify risks and implement appropriate interventions to minimise the risks posed by skin integrity deterioration, falls, fluid restriction, self-administration of medications and driving.

The approved provider responded to the site assessment report and acknowledged deficits in the lack of assessments conducted in relation to one sampled consumer, however, the approved provider stated this was an isolated documentation gap and not a systemic issue. Further assessments were completed for this consumer after the service received relevant input from the consumer’s medical practitioner. In relation to another consumer with missing assessments, the approved provider also submitted updated evidence that a medication self-administration assessment and a driving assessment have now been completed.

I accept the arguments and evidence put forward by the approved provider. While I note a skin integrity assessment for one consumer upon admission to the service was not performed, I also note wound charting commenced two days after they were admitted. There is no evidence before me that there are systemic deficits in assessment and planning at the service, including consideration of risks. Accordingly, I find the service compliant with requirement 2(3)(a).

**Requirement 2(3)(b)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate effective review and consideration of reducing and minimising the use of chemical restraint.

Following a site assessment in November 2022, Assessment Team found that the service did not demonstrate that assessment and care planning information was always updated in a timely manner to reflect the current care needs of a number of consumers with responsive behaviours.

The approved provider responded to the site assessment report and acknowledged deficits in assessment and care planning processes. The approved provider acknowledged documentation gaps, stating that they had identified deficits through internal continuous improvement processes and are prioritising work to rectify issues to ensure they are not repeated. The approved provider also submitted evidence that behaviour charting and behaviour plans for consumers identified in the site assessment report have now been completed. Accordingly, based on the evidence submitted by the approved provider, I find the service is compliant with requirement 2(3)(b).

**Requirement 2(3)(e)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate 3-monthly care reviews were consistently occurring and care plan reviews did not identify when strategies are ineffective and did not prompt reassessment or new interventions.

Following a site assessment in November 2022, the Assessment Team found that care plan reviews remain inconsistent. The Assessment Team identified that two sampled consumers did not have their care plans updated following an incident, nor were mobility and falls risk assessments reviewed following recent falls. In addition, post‑incident behaviour charting and monitoring was not completed.

The approved provider responded to the site assessment report and acknowledged no follow-up reviews took place for sampled consumers including in relation to monitoring their behaviour. The approved provider stated they are trialling a new falls management process and have engaged external consultants to assist them. The approved provider acknowledged that due to multiple competing priorities, on occasion, staff may have overlooked documentation. They argue this is circumstantial, and that they find and remediate these omissions during internal auditing and quality control processes.

While I acknowledge the service is implementing measures to improve falls management processes, improvements are yet to be embedded and evaluated for effectiveness. I also note there was a lack of review following a number of incidents and similar incidents recurred due to the service not implementing strategies to prevent their recurrence. Accordingly, I find the service is non-compliant with requirement 2(3)(e).

# Standard 3

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

Findings

**Requirement 3(3)(a)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate that each consumer receives safe, effective and tailored clinical care in relation to restrictive practices and pain management.

Following a site assessment in November 2022, the Assessment Team found the service did not demonstrate that chemical restraint is understood or managed effectively. Two consumers prescribed psychotropic medications to modify their behaviours did not have informed consent and the service did not recognise them as being chemically restrained. In addition, psychotropic medications are not always used as a last resort, nor monitored or evaluated for effectiveness. The Assessment Team also found one consumer’s care plan does not document the location and type of pain they experience and does not guide staff on pain management strategies. This consumer was commenced on a strong analgesic patch in August 2022 however there has been no monitoring or pain charting since July 2022.

The approved provider responded to the site assessment report and stated that they have engaged an advisory service to assist them to review their practices in relation to restrictive practices and pain management. One of the consumers sampled by the Assessment Team has since had their chemical restraint medication ceased after consultation with representatives and their medical practitioner. The approved provider is also ensuring that there is pain charting and monitoring when new analgesic patches are administered to consumers.

While I acknowledge that the approved provider has made improvements in the management of chemical restraint and pain, improvements are yet to be fully embedded and evaluated for effectiveness. I also note the severe impact insufficiently treated pain can have on consumer health and well-being. Accordingly, I find the service is non-compliant with requirement 3(3)(a).

**Requirement 3(3)(b)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate effective management of high impact or high prevalent risks in relation to diabetes care, medication management and falls.

Following a site assessment in November 2022, the Assessment Team found the service has demonstrated improvement in the management of medication charts that align with the service’s policy and best practice. However, the Assessment Team found one consumer sampled in the assessment report did not have behaviour support interventions available to support staff to minimise the impact on other consumers and staff as this consumer has been involved in 5 episodes of responsive behaviours between 4 October 2022 and 12 November 2022. The Assessment Team found the behaviour care plan for this consumer was incomplete and did not record their responsive behaviours, intervention strategies or their needs or preferences. In addition, the Assessment Team found neurological observations are not consistently taken following falls and one sampled consumer’s mobility and care plan was not updated following 2 falls. In relation to one consumer with diabetes, blood glucose levels were not tested following the administration of insulin on 6 out of 14 occasions between 1 November 2022 and 14 November 2022.

The approved provider responded to the site assessment report strongly refuting the evidence presented by the Assessment Team, stating the report does not demonstrate there has been a negative impact on the quality of life of consumers. The approved provider’s response states the small number of reported incidents in the site assessment report should not determine an adverse finding for the entire requirement based on isolated incidents. The approved provider stated one sampled consumer’s mobility and care plan was reviewed following falls but no changes were required. The service is trialling a new falls process and has engaged an advisory service to assist them to improve their processes further.

The approved provider has now updated the care plan for the sampled consumer with responsive behaviours, with their care plan now including preventative strategies. However, there was no evidence presented by the approved provider of strategies for preventing episodes of aggression when the consumer is triggered by other consumers touching their belongings. There is a continued risk to the safety of other consumers if this is not effectively managed.

While the provider has provided evidence they have rectified some of the deficits identified in the site assessment report, I am not satisfied that they are effectively managing consumers with responsive behaviours, diabetes and following falls. Accordingly, I find the service is non‑compliant with requirement 3(3)(b).

**Requirement 3(3)(g)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate they are implementing or maintaining strategies to minimise the risk of infections.

Following a site assessment in November 2022, the Assessment Team found the service’s management of infection risks was effective. The Assessment Team identified that not all policies and procedures available to staff were current, however, staff were able to demonstrate to them, an understanding of infection prevention and control measures including antimicrobial stewardship and advised they had recently completed refresher training on infection control. The Assessment Team observed staff performing hand hygiene and using personal protective equipment safely. Accordingly, I find the service is compliant with requirement 3(3)(g).

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | 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. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

**Requirement 4(3)(c)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate that services and supports cater to the interests and preferences of consumers.

Following a site assessment in November 2022, the Assessment Team found the service demonstrated that activities consider consumer preferences and interests. The service has implemented processes to engage consumer feedback on activities and most sampled consumers stated they are assisted to participate in the community and to do things of interest to them. Accordingly, I find the service is compliant with requirement 4(3)(c).

**Requirement 4(3)(f)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as sampled consumers consistently provided negative feedback about the evening meal.

Following a site assessment in November 2022, the Assessment Team found the service demonstrated it has processes in place to respond to consumer suggestions regarding menu options. All sampled consumers were satisfied with the quality and quantity of meals. Consumers stated they are provided with choices and changes to dietary requirements are updated as required. The menu is changed every 6 months based on the nutrition and hydration needs of consumers and the menu is reviewed by a dietitian. Consumer feedback is encouraged during ‘residents’ and ‘food focus’ meetings. Accordingly, I find the service is compliant with requirement 4(3)(f).

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

**Requirement 5(3)(b)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as consumers residing in the memory support unit were not able to freely access outdoor areas.

Following a site assessment in November 2022, the Assessment Team found the service demonstrated consumers, including consumers who reside in the memory support unit, are able to move freely and access both indoor and outdoor areas of the service. The Assessment Team also observed the service to be safe, clean, well-maintained, well-lit, and clutter-free. Accordingly, I find the service is compliant with requirement 5(3)(b).

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | 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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

**Requirement 8(3)(d)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not always identify high impact and high prevalence risks to consumers, nor implement remedial actions in a timely manner.

Following a site assessment in November 2022, the Assessment Team found the service did not demonstrate appropriate risk management and review of a consumer’s behaviour to reduce the ongoing impact on other consumers’ well-being. In addition, the service’s risk management and reporting mechanisms are not capturing all incidents that have an impact on consumers, behaviour support plans were not always updated following incidents and there were limited strategies and interventions recorded to guide staff.

The Assessment Team also found the service did not demonstrate how it appropriately manages skin integrity, fluid restriction, diabetes and falls to reduce the risk and impact on consumer health and well-being. Not all processes were followed in relation to performing neurological assessments following a consumer’s unwitnessed fall. There were conflicting medical directives in the care documentation for the management of one consumer’s diabetes. One sampled consumer did not have documentation in relation to their wound dressing and another consumer did not have risk assessments in relation to driving or self-management of medication.

The approved provider responded to the site assessment report stating the incident referred to by the Assessment Team was being investigated at the time of the site assessment and a report has now been submitted. The approved provider has recently updated their falls management process and has stated a trial of the updated process will begin on 1 December 2022. They have also sought assistance from a consultancy and advisory service to assist with improving their processes. The approved provider also states they are committed to ensuring best practice strategies are in place to enhance resident quality of life, individualised strategies and interventions are now included in behaviour support plans and staff are educated in behaviour management and support plans.

While the provider has submitted evidence they have rectified some of the deficits identified in the site assessment report, I am not satisfied that the process and policies in relation to falls management and behaviour management are fully embedded in staff practice. In addition, I am not satisfied the approved provider fully understands mandatory reporting requirements as incidents of aggressive behaviours exhibited by one consumer were either not reported or not reported promptly. I am of the view that these incidents fall within the definition of psychological and emotional abuse as they could reasonably be expected to cause the victim psychological or emotional distress and must be reported. Accordingly, I find the service is non-compliant with requirement 8(3)(d).

**Requirement** **8(3)(e)**

The service was previously found non-compliant with this requirement following a site audit in May 2021 as the service did not demonstrate adequate oversight of antimicrobial stewardship and the use of restraint.

Following a site assessment in November 2022, the Assessment Team identified that policies and procedures relating to antimicrobial stewardship, minimisation of the use of restraint and open disclosure had not been uploaded to the electronic system for staff. Older versions were found on the system, however, this was corrected during the site assessment. Staff demonstrated they understood the principles of antimicrobial stewardship and open disclosure. The Assessment Team also identified that the service has a document recording psychotropic medications and chemical restraint, however, the Assessment Team found this register did not align with best practice as it did not include key details including the reason for the use of the medication, strategies and or interventions to be trialled prior to medication administration, informed consent and review dates. The approved provider submitted a psychotropic register that now contains all of the required information and the service has reviewed all consumers subject to chemical restraint. Accordingly, I am satisfied the service is compliant with requirement 8(3)(e).

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)