Performance

Report

**1800 951 822**

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| Name of service: | Braemar House |
| Service address: | 10 Windsor Road EAST FREMANTLE WA 6158 |
| Commission ID: | 7758 |
| Approved provider: | The Commissioners of the Presbyterian Church in WA |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 April 2023 |
| Performance report date: | 5 May 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 Braemar House (**the service**) has been prepared by K Richards, 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.

# 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 consumers, representatives, staff, management, and others; and
* the Performance Report dated 5 September 2022 in relation to the Site Audit conducted on 20 July 2022 to 22 July 2022.

The provider sent an email on 18 April 2023 acknowledging the Assessment Team’s findings.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been 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.

# 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Requirements (3)(a) and (3)(b) were found non-compliant following a Site Audit undertaken from 20 July 2022 to 22 July 2022, where it was found the service did not deliver safe and quality care in relation to management of pressure injuries and wound care, use of restrictive practice, and weight loss and nutrition and hydration. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Increasing oversight through the weekly Clinical Risk Meeting, including discussion of wounds, use of a weight matrix spreadsheet to identify unplanned weight loss, and monthly review of psychotropic medications by the Nurse manager to monitor and minimise use of chemical restraint.
* Review of policy, procedures, and preferred assessment tools to guide staff on wound care, assessment of nutritional needs, and identification and reporting of skin integrity issues.
* Incorporation of personal and clinical care within a pictorial care plan to guide staff.
* Introduction of the Handover Staff Checklist to ensure communication of consumer care needs.

The Assessment Team was satisfied these actions and improvements were effective.

In relation to Requirement (3)(a), consumers and representatives described how care and services were tailored to meet consumers’ personal needs, expressing satisfaction with care provided. Documentation demonstrated care is provided in line with policies and procedures in relation to management of wounds care, diabetes, restrictive practice, weight, and pain. Clinical staff said referrals are made to the Medical officer or Wound specialist to ensure management aligns with best practice guidelines, and sampled wounds were noted to be improving. Consumers with changed behaviours had detailed behaviour support plans, with regular review of non-pharmacological strategies by the Nurse manager.

The service demonstrated effective management of high impact or high prevalence risks associated with falls, skin integrity, pain management and unplanned weight loss. Staff could identify key risks and management strategies for sampled consumers, along with escalation processes. Management described improvements leading to a reduction of the number of pressure injuries, including ensuring pressure relieving equipment is available for staff to use when risks are identified and recording repositioning and assessment of pain. Consumers at risk of falls were identified through assessment by Allied health staff, with recommended strategies implemented and known by staff, and communication of needs and changes through written and verbal handover processes. Consumers with unplanned weight loss had review of risk of malnutrition and had been referred for Dietitian consultation and medical review where risks were considered to be linked to declining health.

For the reasons outlined above, I find Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 20 July 2022 to 22 July 2022, where it was found the service did not demonstrate safe and effective supports by ensuring use of prescribed equipment, care staff were unfamiliar with positioning or support for the equipment, and clinical management were unaware it was not being used. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Review of handover processes, with updating of the written handover to include required services and supports, such as splints and ambulation aids.
* Ensuring tasks are entered into the electronic care system to prompt staff, with monitoring of completion by clinical staff.

The Assessment Team was satisfied these actions and improvements were effective. Consumers and representatives said they were satisfied services and supports for daily living help consumers do things they want to do and increase or maintain their independence. Assessments are undertaken by Allied health staff in relation to consumers’ needs and/or ability to safely use equipment. Staff were able to describe services and supports for sampled consumers, and how these met consumers’ needs or preferences, optimising their independence or well-being. Consumers were observed using prescribed supportive equipment in line with care plan directives, with one representative confirming they observe the equipment is in place each time they visit.

For the reasons outlined above, I find Requirement (3)(a) in Standard 4 Services and supports for daily living compliant.

# 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. | 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

Requirements (3)(d) and (3)(e) were found non-compliant following a Site Audit undertaken from 20 July 2022 to 22 July 2022, where it was found the service did not have effective systems in relation to managing high impact or high prevalence risks and managing and preventing incidents. Requirement (3)(e) was non-compliant as the service was unable to demonstrate effective governance processes and oversight relating to minimising of restraint.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided staff education on incident reporting, identifying and responding to abuse and neglect of consumers, use of restrictive practice, antimicrobial stewardship, and open disclosure.
* Increased monitoring and oversight of the registers for risk, restrictive practices, and infection to ensure information is correct and current.
* Introduced an audit system for monitoring of clinical care to identify areas for improvement.
* Implemented a new key performance indicator spreadsheet, with incidents and findings reviewed at clinical quality meetings.
* Engaged a Nurse practitioner to provide staff education and guidance.

The Assessment Team was satisfied these actions and improvements were effective.

Staff were able to identify consumers with high impact or high prevalence risks associated with their care, knew processes for incident reporting, and could describe training undertaken in recognising and responding to the abuse and neglect of consumers. Incidents are reported through the current system with prompt investigation and development of actions or improvements. Data on key risks is trended, with opportunities for improvement discussed at staff meetings. Consumers are supported to live their best lives and take risks where they choose, with risk acknowledgement forms completed incorporating mitigating strategies in line with the Dignity of Risk Policy.

For Requirement (3)(e), staff were able to describe processes and provide examples in relation to minimisation of use of restrictive practices, antimicrobial stewardship, and the use of open disclosure. Management advised they follow the organisational policy to use restrictive practice as a last resort, with regular review of medication use and consideration of reduction or cessation. Clinical indicators demonstrated a reduction in use of chemical restraint and the number of consumers subject to all forms of restrictive practice. Care files sampled demonstrated staff are following organisational policies.

For the reasons outlined above, I find Requirements (3)(d) and (3)(e) in Standard 8 Organisational governance compliant.

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)