

**Performance Report**

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| Name: | Esida |
| Commission ID: | 5958 |
| Address: | 79 Foxglove Street, MOUNT GRAVATT EAST, Queensland, 4122 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 25 November 2024 |
| Performance report date: | 10 January 2025 |
| Service included in this assessment: | Provider: 1746 Queensland Rehabilitation Services Pty Ltd Service: 3872 Esida |

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 Esida (**the service**) has been prepared by Bruce Bassett, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others.
* the provider’s response to the assessment team’s report received 16 December 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable as not all requirements were assessed |
| **Standard 7** Human resources | **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.

# 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 report contained information which indicated some consumers did not have reviews following falls and some consumers and representatives often felt fearful and stressed due to the behaviours of other consumers at the service.

Registered staff said they are not always able to complete assessments or monitoring of consumers post falls in a timely or appropriate manner. The Assessment Team report said these statements were corroborated through documentation such as neurological observation charts not being completed in line with the service’s management policy after falls and head strikes.

The service identified skin injuries, falls and aggressive behaviours as their high-impact, high-prevalence risks, but was unable to demonstrate consistent management across all their high-impact-high prevalence risks in line with their own policies.

Consumers and their representatives said consumers do not always have a review by a medical officer (MO) or physiotherapist if they have a fall. Care plans and assessments were not consistently updated after a fall. Registered staff and care staff were able to describe the processes for immediate post falls management. However, registered staff said, and care planning documentation demonstrated, post falls management was not consistently followed in line with the organisation’s policies. The Assessment Team report indicated deficits such as no reviews by MOs or physiotherapists, no reassessment or care plan evaluation in response to falls and unwitnessed head injuries. When feedback was provided to management about these issues, management was unaware the service’s policies were not being followed. The Assessment Team report contained examples where post falls management was not completed in accordance with the service’s falls management policy and procedures.

For example, one named consumer experienced agitation approximately six hours after a fall. She was administered an antipsychotic medication and no further neurological observations or assessments were recorded after the medication was administered. It was unclear from the documentation whether the consumer remained agitated, what was the effect of the drug used, and if there was any ongoing neurological deterioration identified. Increased agitation as a risk post fall was not identified or considered before administering the antipsychotic medication. No further post fall observations were made and statements in the progress notes did not clearly explain the reasons why neurological observations were not completed. They also did not identify whether the consumer’s agitation was assessed as a potential complication from her fall.

The service was unable to demonstrate the consumer was reviewed by a physiotherapist in the days following her fall. Staff were unsure of any reviews completed by the MO or physiotherapist and therefore any further strategies to help reduce the consumer’s falls risk.

The Assessment Team report indicated the care delivered to the consumer did not align with the service’s falls policies, as she was not reviewed by the MO or physiotherapist post unwitnessed fall and neurological observations were not taken at the appropriate times. The service could not demonstrate consideration or monitoring of any risks associated with administering antipsychotic medication to a consumer requiring neurological observation.

In response to the Assessment Team report, the service disputed the characterisation of this consumer’s situation. The response advised the consumer is 100 years old, fully dependent on care and cognitively impaired. The consumer has frequent falls events by ‘rolling off the bed’ onto a positioned crash mat. The service advised this was the situation for the incident in question, and there was no indication of injury or distress. Neurological observations were taken with no adverse indicators and therefore there was no requirement for the consumer to be reviewed by a physiotherapist. The consumer has been prescribed the antipsychotic medication by her MO and has received it periodically since May 2024 for agitation related to her cognitive impairment. Information provided by the service evidenced pain and neurological observation charting was conducted in the days following the incident. I acknowledge the additional information provided by the service and accept it changes the context in which the incident can be assessed.

The Assessment Team report indicated another named consumer sustained a head laceration after a physical altercation with another consumer. The named consumer was on a prescribed anticoagulation medication. Management told the Assessment Team consumers on anticoagulant medications who experience head strikes should attend hospital. Management further stated neurological observations were to be conducted to an outlined schedule for the next 48 hours, as per the policy. The Assessment Team was not provided any evidence the consumer had attended hospital or was reviewed by a MO.

The report said management were unaware the consumer had not attended hospital or was not reviewed by the MO when the Assessment Team bought this forward during feedback. The care provided to the consumer did not align with the service’s policies or statements from management, such as all consumers on anticoagulant medication who experience a head injury should attend hospital.

In response to the Assessment Team report, the service advised the named consumer had received a ‘superficial graze/skin tear’ which was immediately treated via first aid wound management. The incident was captured on CCTV and the injury sustained was not significant, was not the result of a fall or head strike and did not require hospital attendance. Evidence provided by the service demonstrated the consumer’s wound was treated and monitored by registered staff and they were reviewed by a MO two days after the incident who had no concerns regarding the management of the wound. The response also notes the difficulties in managing the behaviour of the consumer during his stay at the service which would have complicated any attendance at a hospital for treatment. Again, I acknowledge the additional information provided and accept it provides a context in which the services policy was understandably not followed to the letter but was in accordance with the needs of the consumer.

Another named consumer who had a recent fall was identified in the Assessment Team report as not having been re-assessed for her falls risk following the incident and the report said the service did not demonstrate monitoring, evaluation, and care planning had taken place to identify and reduce risks for the consumer.

In response, the service advised the named consumer had an unwitnessed fall, being her fourth in 2024 without any injuries, although she did complain of some soreness on the right side. Information provided by the service demonstrated neurological observations were conducted, head to toe assessment undertaken and pain relief provided. The service advised the consumer has a falls management strategy in place and her care plan is reviewed at four monthly intervals. The service advised the incident did not warrant a full re-assessment of her falls risk following the incident and I accept this view following review of the evidence provided by the service.

Therefore, with respect to falls management at the service, I am not convinced on the evidence available to me that the service is failing to manage falls or the risk of falls appropriately. It may be the case that not all falls are reviewed exactly in line with the written policies and procedures of the service, but the provider response shows each fall was reviewed and assessed, neurological observations were undertaken, and treatment and management was provided in accordance with the needs of the individual consumer and their individual circumstances.

With respect to behaviour management, the Assessment Team report indicated consumers and representatives said they had felt unsafe in recent months after witnessing incidents and had concerns for staff due to aggressive behaviours from other consumers. Care staff said they had not received dementia specific training or training in managing challenging behaviours and found some consumers with aggressive behaviours difficult to work with. A review of the incident register and the Serious Incident Response Scheme (SIRS) register showed the service had two consumers who frequently displayed aggressive and at times sexually inappropriate behaviours towards both staff and other consumers.

When this feedback was provided to management, management stated one consumer had been discharged to hospital due to their aggressive behaviours. Management said they had put measures in place for the other consumer. For example, the consumer had a staff member with him between 9.00am and 4.00pm daily as there is no memory support unit within the service. However, those staff were not trained in dementia specific cares or behaviour support.

Four consumers said they had seen the consumer regularly assault staff and display sexually inappropriate behaviours. Some staff said they did not have the training or tools to adequately respond to the consumer’s changed behaviours. When the Assessment Team brought forward staff and consumer concerns, management stated the consumer had not been involved in any assaults, aggressive behaviours, or inappropriate sexual conduct. The Assessment Team found documentation in the incident register, SIRS register and in the consumers progress notes which was inconsistent with management’s statements.

The consumer’s representative stated the consumer had been in several altercations. The representative said these incidents seemed to be increasing but was unsure if the consumer had been referred to specialised services.

Documentation reviewed by the Assessment Team noted recent incidents where the consumer had hit or attempted to kiss staff members. Behaviour charting demonstrated the consumer was exhibiting agitation, inappropriate behaviours, and exit seeking behaviours most days.

Staff advised the Assessment Team they felt scared at times when providing cares to the consumer and felt the strategies in place were not working and had not been updated or reviewed.

In response to the Assessment Team report, the service advised that in the months prior to the assessment contact, the service had taken on several complex residents with behavioural issues. The service acknowledged this had a significant impact on the service community. Additionally, this coincided with disrupted continuity in leadership caused by several management and staff changes. The service disputed some of the details in the Assessment Team report with respect to some specific consumers or incidents, but acknowledged that some residents had felt unsafe, fearful or stressed due to the behaviours of two male residents of the service. Those residents have since exited the service. The service expressed disappointment regarding the experience of consumers at the service.

The response advised of actions implemented or planned to address the deficiencies identified in the Assessment Team report. These included inserting a new Area Manager into the service to provide additional support, coaching and mentoring to the new management team, commencement of a new training facilitator and intensive training sessions for new staff including in behaviour management, and stabilising new admissions to ensure a harmonious balance of the current consumer cohort. Evidence was provided in the response supporting the implementation of these actions.

The service advised they had debriefed consumers regarding their experiences and provided additional emotional support to those impacted by the behaviours of the former consumers. The response included evidence of training provided to staff regarding management of behaviours and recent feedback from consumers indicating satisfaction with how the service operates and from staff indicating they felt more comfortable dealing with behaviours of consumers following the training.

With respect to skin integrity, the service was able to demonstrate registered staff are completing wound care in line with consumers care planning documentation. Consumers and representatives said consumers’ wounds are being well managed. Review of care planning documentation demonstrated the service is referring consumers to the MO or wound specialist.

The service’s plan for continuous improvement (PCI) was reviewed by the Assessment Team. The PCI provided did not contain any items relating to any of the service’s high-impact or high-prevalence risks, such as, but not limited to, behaviour management or falls. An updated copy of the service’s PCI was provided with the response which outlined actions being undertaken to address issues relating to behaviour management, falls and staff training. The PCI indicated the issue to be addressed, how it was to be addressed, who was responsible for the implementation of the actions and progress through to completion.

Following consideration of the above information, I am persuaded that issues concerning the management of behaviours of a small number of consumers were adversely impacting upon other consumers at the time of the Assessment contact. However, I am confident actions taken by the service since that time have not only addressed these issues but will also be sufficient to prevent their recurrence. I have therefore decided that the requirement is compliant.

# Standard 7

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| Human resources |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

The Assessment Team report indicated consumers and representatives said staff had been unable to assist consumers in a timely manner. Consumers and representatives said this had resulted in consumers missing out on meals and beverages and were left in the bathroom unattended for extended periods.

Registered staff stated they would regularly work beyond their shift finish time and still need to hand over cares such as wound dressings to the next shift. Registered staff said they knew how to manage incidents such as falls, but did not have enough time to complete follow up management as per the services policies. Registered and care staff stated there were often staff absent and the service used the extra staff member who was supposed to assist multiple areas when busy to support a single consumer due to his changed behaviour.

In response to this issue, the provider said an additional staff member had been rostered to support the consumer with changed behaviours and argued this was an appropriate measure at the time.

Some consumers/representatives stated consumers had missed meals and not been provided with beverages due to staff stating they were too busy to deliver them to the consumer’s room. One consumer said they were recently left sitting unsupervised on the toilet for over 30 minutes waiting for staff to come back.

At the time of the Assessment contact management was unable to provide a response to feedback to clarify if the consumer did need to wait over 30 minutes for staff to respond to a call bell and stated they were unaware of any consumers waiting this long for assistance.

Management stated, in response to the Assessment Team feedback, they are looking to hire new staff and are currently experiencing a large turnover of staff. Management said this may attribute to the comments from consumers about missing meals, beverages and being left in their bathrooms for extended periods of time.

In response to the Assessment Team report, the provider acknowledged the impact on consumers noted in the report and said there had been significant workforce challenges for the service in the previous six months. The response said the service has a young and relatively inexperienced part-time workforce and this demographic challenge had been increased by complex resident impacts and changes in management. It was acknowledged this placed strain on the capacity for coaching of new staff and workload management. The response indicated the situation has now stabilised with reduced turnover and staff advising their workloads had significantly improved and the number of unplanned absences having rapidly reduced from the previous months. Evidence was provided in the response to support this. It was acknowledged that staff turnover had impacted upon continuity of care. The service is seeking to increase the full-time worker ratio at the service to achieve more continuity of care for consumers.

The Assessment Team report indicated several staff said people who no longer work at the service, or who had not attended shifts for greater than 30 days, were rostered on shifts and included in the daily allocation sheets.

Staff members showed the Assessment Team the roster and daily allocation sheets at the time of assessment contact and said one of the staff rostered had resigned and had not been working at the service for over a month.

Management was presented with this information and denied this was occurring. The Assessment Team requested for documentation pertaining to staff payroll/absences to cross reference with care minutes. This documentation was provided late in the assessment contact and the Assessment Team could not review it further before leaving the service.

In response to the Assessment Team report, the provider refuted the allegation that staff who had been terminated or who had resigned remained on the service’s roster and allocation board. The provider advised all rosters had been externally reviewed by their human resources team and confirmed only active employees were included on the roster. All casual employees who had not worked in the last 3 months were marked as inactive and no former employees were included in rosters or allocations. With respect to the staff member who it was claimed had resigned, but continued to be included on rosters, the response advised the staff member had not resigned, but regularly changed her shift availability without notice. As a mitigating measure, the service had been rostering an additional staff member as cover in the event the rostered staff member did not attend work. The response included evidence that supported the provider’s position.

The Assessment Team review of the service’s direct care minutes indicated minimum requirements had not consistently been met. This information was requested on multiple occasions and only provided to the Assessment Team late in the assessment contact. The report said management provided spreadsheets where key data was missing or unclear. The information provided suggested Registered Nurse and total care minutes were under the minimum requirements. The report recommended the requirement as not met.

The provider response advised an amended staffing model was released in October 2024 to ensure direct care minute requirements were met. The response provided evidence that care minutes requirements for the fortnight prior to the assessment contact were being exceeded on all days excluding weekends. The service advised some information provided to the Assessment Team may have been inaccurate and that the service is acutely aware of their accountability regarding minimum direct care minute requirements and ensuring these are met. The evidence provided in the response confirmed the service is meeting the minimum requirements with regards to direct care minutes provided to consumers.

Following consideration of the above information, I am persuaded that at the time of the assessment contact consumers and staff were adversely impacted by staff turnover, management changes and disruptive consumer behaviours. However, I am convinced by the evidence supplied in the provider response to the report that these issues have been addressed and that the workforce is planned and enabled to provide safe and quality care and services to consumers.

I have therefore decided this requirement is 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)