 Performance

Report

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| Name: | Esperance Aged Care Facility |
| Commission ID: | 7248 |
| Address: | 17 Eyre Street, ESPERANCE, Western Australia, 6450 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 October 2023 to 18 October 2023 |
| Performance report date: | 6 December 2023 |
| Service included in this assessment: | Provider: 626 Esperance Aged Care Facility Inc  Service: 4775 Esperance Aged Care Facility |

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 Esperance Aged Care Facility (**the service**) has been prepared by R, Beaman, 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, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 06 November 2023; and
* the performance report dated 19 January 2023 following a site audit undertaken from 15 to 17 November 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Applicable** |
| **Standard 8** Organisational governance | **Not 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.

**Standard 2 Ongoing assessment and planning with consumers:**

* Requirement (3)(a): Ensure assessments, charts and monitoring records are completed to identify risks in relation to consumers’ care and to inform strategies to manage risks.

**Standard 3 Personal care and clinical care:**

* Requirement (3)(b): Ensure each consumer’s high impact or high prevalence risks are managed effectively, including behaviours, falls, skin integrity, and unexplained weight loss.

**Standard 8 Organisational governance:**

* Requirement (3)(e): Ensure the clinical governance framework in relation to minimising use of restraints and open disclosure is applied effectively.

# 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. | Not 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. | Compliant |

Findings

Requirements (3)(a) and (3)(e) in this Standard were found non-compliant following a site audit undertaken in November 2022 as assessments were not used to inform risks or develop strategies to mitigate risks, and assessments were not being regularly reviewed when an incident, change or deterioration of a consumer occurred. The service implemented improvement actions to address the deficits, including education for clinical staff around assessment processes, care plan review processes and wound management, and increasing the number of medication competent staff to enable clinical staff to undertake regular assessment reviews. At the assessment contact visit in October 2023, the assessment team have recommended both requirements not met.

**Requirement (3)(a)**

The assessment team were not satisfied the service’s assessment and planning process is current or considers risks to inform safe and effective care, specifically in relation to nutrition, restrictive practices and pressure injuries. The assessment team’s report included the following information and evidence gathered through observations, interview, and documentation relevant to my finding:

* One named consumer is charted to receive a nutritional supplement three times daily, but this information does not include the quantity required to guide staff and manage the risk of weight loss. The consumer’s mobility has changed, and they are now bed bound but the care plan information is not up to date to reflect this and does not provide the appropriate mobilising strategies to guide staff to do so safely for the consumer.
* One named consumer who has a risk of pressure injuries did not have a wound management plan commenced when redness was identified on their ankle and a dressing applied. No information was documented about management strategies, including when dressings are to be changed or that the area was to be checked by clinical staff to prevent further deterioration.
* Two named consumers have not been identified as having a restrictive practice in place and they are subject to chemical restraint. Management confirmed both consumers had not had a restrictive practice assessment.
* One unnamed consumer who undertakes an activity of risk did not have this information updated on care documentation and staff could not access the risk assessment to guide delivery of safe care.
* One unnamed consumer’s care plan did not include information about dietary requirements due to allergies as recommended by the speech pathologist.

The provider did not agree with most of the findings in the assessment team’s report and included additional information and commentary in relation to their assertion. In relation to nutritional supplements not being consistently administered to one consumer, the provider’s response included nutritional support records for the consumer showing staff signing where those have been administered or documenting where the consumer has refused dating back to May 2023 to the end of October 2023, along with progress notes showing the consumer’s representative was informed of nutritional care being delivered and the instances of refusal of supplements as they occurred. Progress notes included in the provider’s response also document reviews completed by the dietician with instructions to guide staff to deliver appropriate care in consideration of nutritional risks to the consumer. For the consumers administered psychotropic (anti-psychotic) medication, the provider asserts for one consumer this is not considered a chemical restraint as the general practitioner (GP) prescribed the anti-psychotic medication for a condition and for the other consumer, the provider acknowledged this information was not included in the consumer’s care plan, and information was included to show a review by an external dementia specialist was undertaken with recommendations to assist management of adverse behaviours. In relation to the consumer undertaking a risk activity, the provider asserts the consumer has not been deemed to be at risk while undertaking the activity with the medical assessment for driving completed by the GP.

For the consumer with specific dietary requirements due to allergies and the consumer with pressure injuries, the provider acknowledged that information was missing in relation to each consumer’s care plan and asserted these issues have been addressed. For one consumer a copy of the vital information showing the dietetic review during October 2023 that documents the trialling of a dairy free diet, and the other consumer a copy of the updated skin assessment and an assertion a wound care plan was developed, but not included in the response.

I acknowledge the information and commentary included in the provider’s response. However, I find the service did not demonstrate assessment and planning is consistently undertaken with the consideration of risks to inform the delivery of safe and effective care and services. In coming to my finding, I have considered for the consumers administered anti-psychotic medications, neither has been considered subject to chemical restraint and, as such, has not had an assessment undertaken for restrictive practices. For the consumer who is administered regular anti-psychotic medication for behaviours, I acknowledge the GP has prescribed this medication since June 2023, however, there is no information provided to show there has been an assessment of risk of the medication, including any side effects or the alternative strategies to be trialled to show the medication is used as a last resort. The information in the provider’s response documents the GP noted the reason for the medication as for agitation post severe cerebral irritation on 19 October 2023, the day following the assessment contact visit. There was no information about why the medication was prescribed included in the June 2023 entry. For the other consumer, I have considered information in the provider’s response, including the behaviour support plans and note there is no mention of the anti-psychotic medication the consumer is administered. I also note the information included recommendations from the external dementia specialist which are not recorded in the consumer’s behaviour support plan to guide staff practice that were included in the provider’s response. The provider asserts in response to requirement (3)(b) in Standard 3, this information is available to staff in the nurse’s station in the form of the email, but note it is not included in the assessment and care planning documentation for the consumer.

I have also considered for two consumers, care plans did not include the required information, including risks to their health and well-being of pressure injuries and dietary information. I acknowledge the assertion the provider makes that information was available in other areas of their electronic management system and the additional information, including nutritional supplement records provided, however, I place weight on the information in the assessment team’s report in relation to the consumers administered psychotropic medications and the information not included in care plans for other consumers of which the provider asserts they have implemented actions to rectify.

For the reasons above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)**

The assessment team were not satisfied the service regularly reviewed assessment and planning for effectiveness when changes or incidents occur. The assessment team’s report included the following information and evidence gathered through observations, interview and documentation relevant to my finding:

* Care documentation, including assessments were not reviewed for effectiveness for three named consumers who had multiple incidents of adverse behaviours, including physical aggression towards other consumers.
* One named consumer who was identified with redness of skin on their ankle with dressings applied by clinical staff did not have their care reviewed for effectiveness after this change in condition.
* Management and a clinical staff confirmed consumers’ care and services are reviewed monthly as part of the resident of the day process. One named consumer had not been reviewed monthly as per the service’s procedure.

The provider did not agree with most of the findings in the assessment team’s report and included additional information and commentary in relation to their assertion. I acknowledge the information in the assessment team’s report; however, I have come to a different view and find the service did review assessments regularly, including when changes or incidents occur. In coming to my finding, I have considered the additional information in the provider’s response in relation to the incidents of adverse behaviours, including physical aggression for one consumer. The provider has included in their response multiple versions of the behaviour support plan along with emails from the external dementia specialist that shows care of the consumer was referred for review and reviewed for effectiveness as a result of the incidents of adverse behaviours. In relation to the other named consumer with adverse behaviours, the provider asserts an investigation of the incident was completed by the clinical lead and they identified it was retaliation from the first named consumer and did not review their care and services as they were effective. I have also considered the information in the provider’s response in relation to the consumer identified with redness of skin, including that the consumer was reviewed by the service’s GP which identified there was no skin breakdown or pressure injury and that clinical staff were monitoring the area on the consumer regularly for any changes. I acknowledge the provider has also identified the need for further education of staff who did not follow policy and commence a wound care plan when they suspected skin integrity issues, even though it was later reviewed by the GP as not being a pressure injury or wound.

For the reasons above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | Not Compliant |

Findings

Requirements (3)(a) and (3)(b) in this Standard were found non-compliant following a site audit undertaken in November 2022 as consumers were not receiving safe and effective personal and clinical care and high impact or high prevalence risks associated with the care of consumers were not effectively managed, specifically pain, medication, falls and weight loss. The service implemented improvement actions to address the deficits, including having additional care workers undertake medication course, ensuring wound plans are not updated without a pain score included, falls management policy reviewed, and adding pain assessments to the daily alert list. At the assessment contact visit in October 2023, the assessment team have recommended requirement (3)(a) met and (3)(b) not met.

**Requirement (3)(b)**

The assessment team were not satisfied the service effectively manages high impact or high prevalence risks, specifically in relation to weight loss, behaviour management, restrictive practices, falls and pressure injury prevention. The assessment team’s report included the following information and evidence gathered through observations, interview and documentation relevant to my finding:

* Staff did not effectively manage adverse behaviours, including physical and verbal aggression of consumers towards other consumers for four named consumers. Care plans for the four consumers were not always reviewed to determine if behaviour management strategies were effective.
* One of the named consumers had multiple incidents of physical aggression and intrusive behaviour towards other consumers and staff between August and October 2023 without review of strategies to manage those behaviours. Staff confirmed the consumer’s behaviours. Management advised a review by a dementia specialist had occurred but did not provide the assessment team with the report, and the consumer’s care plan did not include any additional recommendations.
* The consumer is administered psychotropic medication to manage their behaviours without informed consent or inclusion on their behaviour support plan and the service does not recognise or consider this a chemical restraint.
* One named consumer has not had their weight effectively managed. The consumer’s care plan documents a nutritional supplement is prescribed three times daily and they have been reviewed by the dietician five times between September and October 2023, but staff have not effectively monitored the consumer’s nutritional intake and over four weeks they received the nutritional supplement only six times. Management advised there was no documentation to confirm the consumer’s intake of supplements.
* Strategies were not always implemented for a pressure injury for one named consumer and the consumer was observed with no additional pressure relieving strategies in place. Staff were unable to confirm what these were, and the last assessment was completed in August 2022.
* Two named consumers did not have their falls effectively managed, staff were not investigating the cause of falls and no evaluation of strategies to prevent further falls.

The provider did not agree with most of the findings in the assessment team’s report and included additional information and commentary in relation to their assertion. In relation to the consumer with adverse behaviours, the provider’s response included copies of the consumer’s behaviour support plan updated in June 2023 and also 18 October 2023 (final day of the assessment contact) which included strategies to manage the consumer’s behaviour. The provider also asserts the external dementia specialist referral was actioned and took place post the assessment contact and included the recommendations from that and previous correspondence with the specialist that included recommended strategies to trial. The provider also included information in relation to the consumer with weight loss of nutritional supplement records that indicate nutritional supplements were provided, where refusal occurred and progress notes of when reviews occurred in relation to nutrition and weight loss with recommended strategies implemented. For the consumer noted in the assessment team’s report as having a pressure injury, the provider’s response includes information that asserts it is not a pressure injury and skin integrity has not been compromised, and for the two consumers with falls additional information, including referrals to the GP and documentation of the incidents occurring. While the provider acknowledges incident forms were not completed in line with their expectations of their clinical staff, they assert all falls were investigated and strategies reviewed, and staff educated on incident management.

I acknowledge the information in the provider’s response; however, this requirement has an expectation that each consumer will have effective management of their high impact or high prevalence risks associated with their care and I find the service did not demonstrate this. In coming to my finding, I have considered the evidence in the assessment team’s report in relation to the consumer with adverse behaviours that includes they were administered a regular dose of anti-psychotic medication to manage adverse behaviours without informed consent being sought. I acknowledge the consumer entered the service with the medication and the service were seeking from the GP information about prescription, however, there is a requirement to have informed consent which was not evident. I also acknowledge the recommendations from the dementia specialist were in the nurse’s station and that these should have been transcribed to the consumer’s behaviour support plan but were not. In relation to behaviour management, the evidence before me does not indicate the strategies to manage the behaviour for this consumer were effective or reviewed following incidents to prevent further occurrence and the risk of harm to the consumer or other consumers. I acknowledge the dementia specialist review occurred post the assessment contact due to the location of the service, however, the behaviour support plan does not indicate the documented successful interventions were effective, specifically when the incidents continued between August and October 2023 and the last review of the consumer’s care plan was June 2023.

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

In relation to requirement (3)(a), consumers and representatives confirmed satisfaction with consumers’ personal and clinical care and felt it was tailored to their needs, goals and preferences. Staff were able to describe how they tailor care to consumers’ needs and documentation confirmed consumer care plans include best practice strategies to guide staff to deliver safe care.

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

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirements (3)(c) and (3)(d) in this Standard were found non-compliant following a site audit undertaken in November 2022 as appropriate action had not been undertaken in response to complaints and feedback and that information was not used to improve care and services. The service implemented improvement actions to address the deficits, including weekly scheduled collection of feedback and complaints boxes, timely response to complaints, and analysing complaints on a monthly basis and using that data for continuous improvement.

At the assessment contact visit in October 2023, the assessment team recommended requirements (3)(c) and (3)(d) met. Consumers and/or representatives were satisfied with the way staff and management respond to their feedback, including complaints, and confirmed this was done in a timely manner. Staff described ways in which they actioned complaints on behalf of consumers and provided examples of when they have used open disclosure when things go wrong. Documentation confirmed timely follow up when complaints are made, and consumer feedback is used to improve care and services. Consumers expressed satisfaction their suggestions were used to improve care and services.

For the reasons detailed above, I find requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints 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. | Not Compliant |

Findings

Requirements (3)(d) and (3)(e) in this Standard were found non-compliant following a site audit undertaken in November 2022 as effective risk management or clinical governance systems were not demonstrated, specifically in relation to high impact or high prevalence risks, incident management, and minimising the use of restraint. The service implemented improvement actions to address the deficits, including recruitment of a full-time training officer, adding consumer weight loss to the clinical risk and governance review meeting agenda, reviewing, and updating the Restrictive Practices policy and psychotropic register. At the assessment contact visit in October 2023, the assessment team have recommended requirements (3)(d) and (3)(e) not met.

**Requirement (3)(d)**

The assessment team were not satisfied the service’s risk management framework effectively monitors and manages incidents or supports consumers to live their best life. The assessment team’s report included the following information and evidence gathered through observations, interview and documentation relevant to my finding:

* The service does not maintain a risk register, including risks to consumers or those partaking in risk activities, and there is no oversight of roles and responsibilities for compliance of risk.
* Incident management is not monitored effectively, and incidents are not always reviewed for effectiveness of strategies to prevent further occurrence. Incidents are not investigated, and incident reports did not document steps taken to determine what had occurred and why.
* One incident where a staff member did not report an allegation of sexual assault as an incident and investigation was not undertaken. The staff member recorded the allegation on the consumer’s behaviour chart instead of reporting as per the organisation’s incident management policy and procedures.
* Incidents that are required to be reported to the Commission and/or Police were not always done in required timeframes. One incident that occurred in early July 2023 was not reported for until the end of September 2023.

The provider did not agree with most of the findings in the assessment team’s report and included additional information and commentary in relation to their assertion. The provider included with their response the organisation’s risk management framework policy, risk register and the service’s serious incident response scheme (SIRS) register. The provider asserts investigations are undertaken by clinical staff at the time of incidents occurring, however, in their response acknowledge that clinical staff are not always documenting the outcomes of investigations in a timely manner and advised they have implemented immediate education to ensure staff follow the organisation’s incident management processes.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service has an effective risk management framework. In coming to my finding, I have considered the information included in the provider’s response that shows the organisation maintains a risk register which considers risks to the service, organisation and consumers, along with strategies to mitigate those. I have also considered the organisation’s incident management system and find the provider’s response showed incidents are recorded and reported as they are required to be and whilst investigations are not documented there is no evidence to show these are not completed and acknowledge the provider has put in place immediate actions to rectify staff practice of not documenting outcomes.

In relation to the consumers undertaking activities of risk, the provider included in their response risk acknowledgement forms for consumers who wish to take risks which outline the risks and strategies to ensure consumer safety. I acknowledge for one incident staff did not report an allegation in a timely manner and the clinical manager followed this up, however, I am not persuaded this is a systemic issue with the organisation’s risk management system.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance compliant.

**Requirement (3)(e)**

The assessment team were not satisfied the organisation’s clinical governance framework is effective in minimising the use of restraint and open disclosure practices. The assessment team’s report included the following information and evidence gathered through observations, interview, and documentation relevant to my finding:

* Two consumers residing in the memory support secure wing did not have environmental restraints identified and were not on the restrictive practice register.
* Two consumers administered psychotropic medications were not identified as subject to chemical restraint and did not have informed consent.
* Record keeping practices did not show open disclosure was followed when incidents or near misses occur.
* Management provided an incident to show open disclosure was undertaken, however, it was not completed until 12 days after the incident occurred.

The provider did not agree with the findings in the assessment team’s report and included additional information and commentary in relation to their assertion. The provider included with their response the restrictive practice consent forms for the two consumers who are administered psychotic medications and a next of kin notification request form which the provider asserts is used to guide staff on when to call representatives after an incident has occurred. I acknowledge the information and commentary the provider has included in response to the assessment team’s report; however, I find the clinical governance framework is not effective in minimising the use of restraint or open disclosure. In coming to my finding, I have considered the information in the assessment team’s report in this requirement and requirement (3)(b) in Standard 3 that for two consumers, administration of psychotropic medications, including anti-psychotic medication was done so without informed consent. I acknowledge the assertion the provider makes for one consumer that they entered the service with the medication and the dementia specialist has not ceased the medication, however, I have placed weight on the evidence that shows the consumer was administered medications without discussion about risks of those medications or valid informed consent. For the other named consumer, I acknowledge the assertion by the provider that the GP prescribed the medications for a brain irritation, however, in the GP notes provided it is also recorded the medication is for agitation and there is also no evidence of valid informed consent or discussion of risk.

In relation to open disclosure, whilst not included in the provider’s response, I acknowledge the organisation has an open disclosure policy as outlined in requirement (3)(c) in Standard 6 of the assessment team’s report. However, in relation to the incident that occurred where open disclosure was significantly delayed, I find the system was not effective in ensuring open disclosure occurs when it is supposed to. Whilst the provider assets the 12-day delay in advising the representative of the incident occurring, they also included commentary advising this was done so a thorough investigation could be done also stating Police were involved in this. I acknowledge the provider’s commentary and the additional information, however, the intent of open disclosure as it relates to the Quality Standards is that it is done so in an open, honest, and timely manner which did not occur, and the organisation’s governance systems did not identify this as an issue.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-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)