Performance

Report

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| Name of service: | Estia Health Flagstaff Hill |
| Service address: | 40 Skyline Drive FLAGSTAFF HILL SA 5159 |
| Commission ID: | 6191 |
| Approved provider: | Estia Investments Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 September 2023 |
| Performance report date: | 23 October 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 Estia Health Flagstaff Hill (**the service**) has been prepared by A. Kasyan, 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 staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 5 September 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The assessment team assessed requirement 3(3)(b) and have recommended it as not met because they found the service did not effectively manage risks of falls, risks associated with psychotropic medications and changed behaviours. The findings were based on the following evidence and information.

In relation to risk of falls:

* Whilst the service has systems to re-assess consumers after each fall and the service was taking actions to reduce incidents of falls using support of the quality specialist, these systems and processes were ineffective in identifying potential contributing factors for each consumer.
* Incident report data showed an increase in falls over the last three-month period with one consumer having sustained a significant number of falls during this period.
* A representative of a consumer who had experienced many falls advised in their view the consumer has had many falls because they are impatient, and they fall while attempting to walk independently and because of the timeframe it takes for staff to come and assist them. The consumer advised staff do not always come quickly enough or do not respond to the call bells.
* Staff had not considered all risk factors, such as continence, that may contribute to the consumer’s falls and advised the consumer can deny assistance with continence care.

In relation to the risks associated with psychotropic medications:

* Although Behaviour Support Care Plans captures triggers, strategies and interventions to manage the consumers’ changed behaviours, it does not include how psychotropic medication is to be used, monitored and reviewed including duration, frequency and intended outcomes.
* In 2 out of 3 sampled files, there was no evidence of the discussion held between the prescriber and representative for the prescribing and use of psychotropic medication.

In relation to management of changed behaviours:

* One consumer was observed to be entering the dining room and another consumer’s room looking for food and was told to go back to their room by staff.
* This action was not in line with the recommendations in the consumer’s care plan from Dementia Services Australia to whom the consumer was referred to for food seeking behaviours.

The provider disagrees with the findings in the assessment team’s report and includes additional information and supporting evidence in relation to management of falls and psychotropic medication risks across the service in general and specifically in relation to the consumers mentioned in the assessment team’s report. Supporting evidence include abstracts from care plans, progress notes from general practitioner, clinical and allied health professionals, assessments, average call bell response time data and medication profiles.

In relation to the observation of staff telling the consumer to go back to their room when they were looking for food, the provider responds by stating their investigation of the situation showed the consumer was explained by staff they have eaten their lunch and would soon receive additional food. A staff member came to redirect the consumer when they were observed to be entering another consumer’s room. The review of the situation showed that staff behaviour was acceptable and was in line with the consumer’s Behaviour Support Plan.

After reviewing the evidence and information presented in the assessment team’s report and the provider’s response, I find requirement 3(3)(b) compliant. I find the service has systems and processes to effectively manage high impact/high prevalence risks associated with personal and clinical care of each consumer, including around falls, psychotropic medications and changed behaviours.

In relation to risk of falls:

* The service provided evidence of individualised consumer care plans, including for the consumer mentioned in the report. The care plan shows the service have considered the consumer’s unique factors contributing to high risk of falls addressing the specific needs and behaviours of the consumer and strategies to mitigate the risks, including continence care needs.
* Whilst the consumer continues to experience falls, incidents of falls are gradually decreasing. The service identified and addressed the main contributing factors of high risk of falls and these are the consumer’s poor mobility, severe cognitive impairment and not wanting to wait for staff to assist with mobility and toileting and declining assistance. The service demonstrates it is actively engaged in efforts to minimise these risks and tailor their strategies to the consumer’s changed needs. The examples of these strategies include, but are not limited to alarm mats usage, scheduled toileting program, pain management and restorative rehabilitation program aimed to maintain the consumer’s strength which is often declined by the consumer.
* Furthermore, an average response time to the consumer’s call bells is 2 to 3 minutes which I consider to be a reasonable response time demonstrating staff is readily available to assist the consumer.
* Lastly, I have considered continuous improvement activities commenced prior to the assessment contact in response to an increase in falls incidents across the service. Supporting evidence included in the response shows the provider’s ongoing efforts to analyse incident reports, identify trends and make improvements in fall prevention measures.

In relation to the risks associated with psychotropic medications:

* Whilst the assessment team found lack of documented evidence of informed consent, how psychotropic medication is to be used, monitored and reviewed, the provider’s response provides relevant evidence, including progress notes from general practitioner and clinical team, “as required” psychotropic medication weekly reviews, records confirming medication is used to treat a diagnosed condition, consultation with consumer/and or their representative, restrictive practices care plans and monitoring of side effects following its use.

In relation to management of changed behaviours:

* Evidence in the provider’s response shows the service identified risks associated with overeating for the consumer mentioned in the assessment team’s report and put strategies in place in line with the recommendations of dietician and Dementia Services Australia. The service monitors effectiveness of these measures in various ways, including through regular weighing. The consumer’s weight is stable and within a healthy weight range.
* Whilst the assessment team’s report state staff were observed to communicate with the consumer in a way that was not aligned with the consumer’s care plan, it did not specify how this demonstrate ineffective management of the consumer’s changed behaviours.

For the reasons detailed above, I find requirement 3(3)(b) compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)