Performance

Report

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| Name: | Finncare Aged Care |
| Commission ID: | 5131 |
| Address: | 343 Cleveland-Redland Bay Road, THORNLANDS, Queensland, 4164 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 12 March 2024 |
| Performance report date: | 9 April 2024 |
| Service included in this assessment: | Provider: 331 Finncare Incorporated  Service: 3488 Finncare Aged Care |

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 Finncare Aged Care (**the service**) has been prepared by Kimberley Reed, 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 and request for information, received 28 March 2024 and 05 April 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **Not applicable as not all Requirements were assessed** |
| **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.

* Consumers who deteriorate need to be recognised identified and provided with timely response to the change in their condition.
* Serious incidents need to be identified and reported to the relevant authorities.

# 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 |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |

Findings

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

High impact and high prevalence risks to consumers were managed effectively via clinical review and included other health professionals when required. Staff described the main risks to consumers and the risk mitigation strategies in place and consumers and representatives were satisfied with the care that consumers received. Strategies to mitigate risks were implemented, management reviewed trends and analysed clinical incident and quality indicator data which was reported within the organisation.

Review of care documentation for consumers at risk of falling evidenced directives for staff in managing each consumer and effective management of incidents relating to falls in line with the service’s falls management policy. Interventions following a fall were known by registered staff and were in line with the service’s falls management policy. The service’s plan for continuous improvement included initiatives relating to falls management, including monthly falls management meetings and falls management education.

Requirement 3(3)(d) Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

While care documentation generally reflected deterioration or changes in a consumer’s condition was identified and actioned, for one named consumer with deteriorating health, actions were not taken in a timely manner which resulted in negative outcomes for the consumer. The service’s own monitoring processes did not identify poor care outcomes for the named consumer, and this poses a risk to other consumers who may deteriorate.

For the named consumer, progress note entries evidenced the consumer was experiencing nausea and discomfort requiring antinausea and reflux suppressant medication for longer than two weeks but was not reviewed by a medical officer or referred for additional assessment. The consumer was sent to hospital via ambulance on 16 February 2024. Concerns were raised with staff at the service regarding the delay in escalating the consumer’s symptoms or seeking an assessment of the consumer’s condition. Staff provided feedback the consumer’s regular medical officer was on leave during this period and an alternate source of medical assessment was not sought. Staff stated the consumer refused transfers to hospital during this period, however, there was no documentation which recorded the consumer’s refusal to transfer to hospital. Despite the service having a relationship with a local hospital specialist geriatric service, there was no evidence to support the service was engaged to assist in the management of the deteriorating consumer.

As per the Approved provider’s written response to the Assessment contact report, the service has expedited and implemented several improvements to address deficits which resulted in a recommendation of Not met in this Requirement.

Improvement actions include the following:

* A series of toolbox education sessions for registered staff and personal care workers was commenced in relation to identifying and responding to consumer deterioration. Education records indicated nine registered staff members attended training on 26 February 2024 and two additional registered staff attended training in March 2024 (no date was provided). Six personal care workers attended toolbox training in relation to responding to deterioration in March 2024 (no date was provided). I am unable to determine from the information provided by the Approved provider, what percentage of staff these numbers represent or if there are any plans to implement this training as a mandatory topic. I am also unable to determine how the Approved provider has tested the effectiveness of this training.
* Clinical management staff have liaised with the Comprehensive Aged Residents Emergency Partners in Assessment Care and Treatment (CAREPACT) to organise education on recognising deteriorating consumers. Training will be focused on care staff initially as the service have recognised care staff are usually the first person in contact with the deteriorating consumer. No dates have been recorded for the delivery of education regarding deteriorating consumers to care staff via CAREPACT. There is no information to support registered staff will receive education from CAREPACT relating to the deteriorating consumer.
* A Continuous improvement form has been created to identify the issues and mitigation strategies for the named consumer. The consumer was reviewed by their Medical officer 14 March 2024, and was subsequently transferred to hospital for further review on the same date. Actions following the hospital admission included medication changes, specifically in relation to medication to treat nausea. It is noted that despite the discharge summary indicating an increase to the medication to treat the consumer’s nausea, this was not actioned by the consumer’s Medical officer for seven days, despite the service contacting the Medical officer on two occasions (14 and 18 March 2024). It is also noted that attempts for the medication to be prescribed and dispensed by other sources such as an after hours medical service were not sought by the service.
* Pain charting was commenced from 13 March 2024 with an evaluation completed 18 March 2024. A progress note entry dated 13 March 2024 which contained an email sent to the consumer’s Next of kin included information the consumer’s pain levels would be strictly assessed every hour including overnight. A review of pain charting submitted by the Approved provider does not support hourly assessment of the consumer’s pain occurred. For example, there is no recorded assessment of the consumer’s pain between 9.17pm 13 March 2024, and 8.30am 14 March 2024. It is noted through progress note entries the consumer required pain relief at 4.41am 14 April 2024, however, this is not recorded on the pain chart. It is also noted that pain charting was not completed between 12.25pm 14 March 2024 and 8.40pm 15 March 2024 (a gap of 20 hours). Progress note entry dated 14 March 2024 and completed at 3.55pm evidenced the consumer was provided pain relief, which was not effective, however, this information was not recorded in pain charting documentation. While it is noted the consumer was sent to hospital on 14 March 2024, progress note entries evidence the consumer returned to the service at 8.30pm 14 March 2024. There is progress note entries to support the consumer was provided further pain relief on five further occasions (11.37pm 14 March 2024, 6.26am 15 March 2024, 12.11pm 16 March 2024, 10.23pm 16 March 2024, and 5.55am 17 March 2024). These administrations of pain relief were not recorded on the pain charting. The evaluation of the consumer’s pain completed 18 March 2024 indicated the current pain management for the consumer was effective. I am unable to determine how the pain charting was utilised to determine the consumer’s pain was effectively managed as records of the consumer requiring pain relief were absent from the pain charting.
* Staff have been provided with toolbox training on writing an effective progress note. Training records indicate nine registered staff, and six care staff completed this training in March (no date was recorded). I am unable to determine the effectiveness of this training, or how this training will improve staffs’ recognition of a deteriorating consumer via documents submitted by the Approved provider.
* The Approved provider submitted a Daily clinical monitoring chart as evidence to support the Registered nurse supervisor reviews progress notes daily, creates a document for the Registered nurse on duty to monitor or follow up on identified issues, and sign off as completed at the end of their shift. Any identified gap or issue is to be actioned immediately and a progress note completed by the Registered nurse supervisor. I notice an absence of any information from the Registered nurse supervisor in relation to gaps in recording the named consumer’s pain levels hourly or the absence of pain relief provided on pain charting.

In coming to my decision regarding compliance in this Requirement, I have taken into account the absence of escalation or referral for the named consumer despite their health deteriorating over a period longer than two weeks. I am also not convinced improvement activities have been effective as it is noted pain charting and evaluation processes were flawed, training delivered has not been tested to determine its effectiveness, some training is yet to be delivered to registered staff and daily monitoring processes did not identify deficiencies in staff practices as it relates to pain monitoring for the named consumer.

Therefore, it is my decision this Requirement is Non-compliant as the deterioration of a consumer was not recognised or responded to in a timely manner, monitoring processes failed to identify the deterioration of the consumer and rectification actions have yet to be determined as effective in addressing this systemic issue.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The service had systems in place to recruit and ensure staff were competent and had the necessary qualifications and required skills and knowledge to provide care and services. Feedback from consumers and representatives identified they felt the workforce was competent and staff had the knowledge to deliver care and services that met the needs and preferences of consumers. The service’s position description templates established responsibilities, knowledge, skills and qualifications for each role. The service’s processes for monitoring staff included criminal record checks, banning orders, staff vaccination requirements, and the Australian Health Practitioner qualifications. Staff competency was determined through skills assessments and was monitored through performance assessments, consumer and representative feedback, audits, surveys and reviews of clinical records and care delivery.

While it is noted that Non-compliance has been found in Requirement 3(3)(d), it is my opinion this does not relate to staff competency or skill, rather the Non-compliance relates to ineffective monitoring processes.

# 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. | Not 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) Effective risk management systems and practices, including but not limited to the following:

(i) managing high impact or high prevalence risks associated with the care of consumers;

(ii) identifying and responding to abuse and neglect of consumers;

(iii) supporting consumers to live the best life they can

(iv) managing and preventing incidents, including the use of an incident management system.

While risk management systems and practices are evident at the service, these practices were ineffective in identifying serious incidents that required escalation and timely notification. The Assessment contact report contained evidence of two serious incidents (one of unreasonable force and the other of neglect) which were not identified as serious or reported to the appropriate sources in a timely manner.

The Approved provider in its written response apologised for the oversight and acknowledged the significance of adhering to deadlines and ensuring timely submissions. Retrospective incidents have been submitted to the Serious incident response scheme (SIRS) and copies of these reports were included in the Approved provider’s response to the Assessment contact report. The Approved provider further added in their response a SIRS flow chart and definitions have been developed to guide staff. Training records indicate seven registered staff have completed toolbox training relating to SIRS in March 2024. Six registered staff attended training relating to time sensitive medication in March 2024, as the incident of neglect related to missed anticoagulant medication.

In coming to my decision regarding compliance in this Requirement, I have considered the Approved provider’s response and I consider the monitoring processes in place at the service have been ineffective in identifying, escalating and reporting serious incidents. I have no information to support toolbox training has been effective in increasing staffs’ knowledge of serious incidents and their reporting requirements. Therefore, it is my decision this Requirement is Non-compliant as risk management processes failed to identify the possible abuse and neglect of consumers.

Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:

(i) antimicrobial stewardship;

(ii) minimising the use of restraint;

(iii) open disclosure.

The organisation had effective clinical governance framework embedded into systems and practices with policies, procedures, and training available to guide staff practice. Management and staff had a shared understanding of the framework in place to guide staff in the provision of care and the organisation’s systems for reporting, monitoring and analysing clinical indicators.

Clinical oversight was provided by the Care Manager and Registered Nurse Supervisor, who both attend and monitor handover and care huddles twice a day, review progress notes daily and review clinical indicators monthly with a report provided to the clinical working group which consists of the Board, General Manager and Care Manager.

Consumers and representatives confirmed, open disclosure was practiced for all incidents and feedback and complaints when required. The quality governance framework was supported by the clinical governance, antimicrobial stewardship, minimising restrictive practices and open disclosure policies amongst others.

The organisation may benefit from a review of monitoring processes in relation to the provision of care and services, as Non-compliance has been identified in two Requirements relating to failure to identify a deteriorating consumer and failing to identify serious incidents.

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)