Performance

Report

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| Name: | Florence Price Gardens |
| Commission ID: | 2681 |
| Address: | 11 Hackett Lane, BALLINA, New South Wales, 2478 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 2 July 2024 to 3 July 2024 |
| Performance report date: | 1 August 2024 |
| Service included in this assessment: | Provider: 643 RSL LifeCare Limited  Service: 1038 Florence Price Gardens |

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 Florence Price Gardens (**the service**) has been prepared by T Coulton,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, and consumers/representatives
* the provider’s response to the assessment team’s report received 23 July 2024 and 29 July 2024

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **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.

* Effective systems in place to ensure time sensitive medications are administered as prescribed to mitigate risks associated with the clinical care of consumers.
* Identify and respond to incidents to manage high impact and high prevalence risk in relation to the administration of time sensitive medications, administration of vaccinations and reporting consumer neglect to the Serious Incident Response Scheme.

# 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. | Not Compliant |

Findings

The Site Assessment report brought forward deficiencies in relation to effective systems to ensure time-sensitive medications are administered within 30 minutes of the time prescribed; and the management of a consumer’s changes in verbal behaviours.

Time sensitive medications

Following an Assessment Contact conducted on 19 March 2024 the service was found non-compliant in Requirement 3(3)(b). Deficiencies related to the service being unable to demonstrate consumers are administered time sensitive medication as prescribed.

In response to the deficiencies identified during the Assessment Contact the service has:

* Provided registered staff with training in relation to time-sensitive medication management.
* Developed a system where management audits daily the administration times of time-sensitive Parkinson’s disease medications and investigates why medications are not administered as prescribed.
* Registered staff complete an incident report for Parkinson’s disease medications not administered as prescribed.
* Reviewed consumers’ Parkinson’s disease time sensitive medications and referred to the medical officer if the charted medication times required altering to ensure the therapeutic time was prescribed.
* Time-sensitive medication is separated by the pharmacist into coloured packaging to assist with identifying the medications and ensuring there is sufficient stock of the required medications.

The Site Assessment report identified ongoing deficiencies in relation to the appropriate administration of time sensitive medications.

* Incident data reviewed for 1 April 2024 to 2 July 2024 identified 21 medication incidents where time sensitive medication was not administered as prescribed and 21 incidents where the medication was administered at the correct time but not signed when administered.
* Whilst management monitors time sensitive medication for the treatment of Parkinson’s disease is administered on time, time sensitive medication for the treatment of other diseases is not monitored by the service to ensure medication is administered as prescribed.

These deficiencies were raised with management at the time of the Assessment Contact by the Assessment Team and in response management advised:

* Management is providing feedback to staff in relation to incident medication management and initiatives have been introduced to encourage staff to administer at the time medications are prescribed.
* Medication incidents are discussed regularly at staff meetings. However, review of meeting minutes identified analysis and risk mitigation strategies of medication incidents was not discussed.

The provider’s response to the Site Assessment report included documented evidence:

* A demonstrated improvement in the appropriate administration times for antiparkinsonian medications.
* Registered nurses complete morning medication round rather than medication administration competent care staff.
* The service’s continuous improvement plan includes an open action for the oversight of time sensitive medication incidents, by the provider’s clinical governance team.
* The provider is in the process of implementing an electronic medication management system, which will include an increase in electronic devices for registered staff to access for co-signing of medication administration.
* In the response the provider did not include systems to monitor appropriate administration times for all time sensitive medications other than medications prescribed for Parkinson’s disease. Review of the incident data submitted by the provider did not evidence time sensitive medications other than Parkinson’s disease medications was monitored.

While I acknowledge the service is addressing some of the deficiencies relating to the administration of time sensitive medications, however the improvements are yet to be fully implemented and evaluated for effectiveness.

Behaviour Management

The Site Assessment report brought forward information the service had not implemented recommendations from community dementia services to manage one named consumer’s changes in behaviours and staff did not have a shared understanding of the consumer’s triggers for changes in behaviours.

The provider’s response to the Site Assessment report included documented evidence of measures taken to appropriately support one named consumer, specifically with changes of behaviour identification and interventions:

* The behaviour management plan included triggers and interventions and the recommendations from the community dementia service.
* Communication with the community dementia service regarding the trialling of interventions and evaluating for effectiveness.
* Behaviour charting when changes in behaviours occur with staff recording strategies and interventions provided.
* The service’s continuous improvement plan includes, for the named consumer, a weekly review by the medical officer with family involvement in the development of interventions to manage changes in the consumer’s behaviour.
* The clinical team monitor the named consumer for deterioration and appropriately refer to other health professionals as required.
* Progress notes identify the named consumer’s pain is frequently monitored and non-pharmacological and medication are provided to manage the consumer’s pain.

I acknowledge the documented evidence submitted by the provider demonstrates the named consumer’s changes in behaviours and triggers for changes in behaviours are appropriately managed by the service.

For the reasons detailed in relation to the service not demonstrating time sensitive medications are administered as prescribed, I find Requirement 3(3)(b) is Non-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. | Not Compliant |

Findings

The Site Assessment report brought forward deficiencies in relation to the effectiveness of systems to identify and mitigate risk; and identify and report consumer neglect to the Serious Incident Response Scheme.

The Site Assessment report brought forward evidence 4 consumers had received an influenza vaccination against the consumers’ substitute decision makers’ documented direction. One consumer, who had a documented allergy to the COVID-19 vaccination, had requested and was administered the COVID-19 vaccination without the risk of the COVID-19 vaccination allergy discussed with the consumer. The service’s continuous improvement plan did not include the review of vaccination incidents to mitigate these risks in the future and these incidents were not reported to the Serious Incident Response Scheme.

The Site Assessment report brought forward information of 21 incidents of late administration of time sensitive medication from 1 April 2024 to 2 July 2024 was not reported to the Serious Incident Response Scheme. The service is not monitoring and has not developed a system to ensure all time sensitive medication is administered within the prescribed time frames.

The provider’s response to the Site Assessment report included documented evidence of actions taken since the Assessment Contact:

* The continuous improvement plan has open actions include:
  + Review the service’s process for providing vaccinations to mitigate risk related to:
    - Consumers or the consumer’s substitute decision maker (when the consumer has been deemed by a medical officer to not have the capacity to consent to the treatment) providing informed consent obtained by the vaccination prescriber is communicated to other health professionals administering the vaccination.
    - Consumers’ medication allergies are communicated to staff or other health professionals administering vaccinations.
  + Provide staff training on informed consent, consumers’ capacity to make informed consent and the Serious Incident Response Scheme in relation to medication errors and neglect.
  + Weekly review of the service’s continuous improvement plan with regional Clinical Governance support to monitor effectiveness of actions.
  + Daily monitoring of time-sensitive medication by management and reporting of incidents to the Serious Incident Response Scheme.
  + All medication errors that are classified as neglect by the Quality Standards are to be reported to the Serious Incident Response Scheme.

While I acknowledge the service is addressing the deficiencies relating to medication incidents and appropriate reporting of medication incident to the Serious Incident Response Scheme the improvements are yet to be fully implemented and evaluated for effectiveness.

For the reasons detailed, I am satisfied Requirement 8(3)(d) is 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)