Performance

Report

**1800 951 822**

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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: | on 19 March 2024 |
| Performance report date: | 16 April 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 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 received 04 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 |

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.

* The risk to consumers in relation to the administration of time sensitive medication needs to be effectively managed.

# 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 service was found to be Non-compliant with this Requirement following an Assessment contact conducted 12-13 December 2023. Despite the service committing to implementing improvement actions, deficits remain in relation to the administration of time sensitive medication as evidenced in the Assessment contact report following an Unannounced Assessment contact visit 19 March 2024. The service did not demonstrate effective monitoring and analysis of the improvements to ensure they were effective and had not been recording medication incidents.

For five consumers diagnosed with Parkinson’s disease, medication records did not demonstrate their medication was administered as prescribed. For one named consumer there were 18 occasions (in a 24 day period) when their medication was not administered as prescribed, and timeframes between dosages were not therapeutic.

The Approved provider in its written response to the Assessment contact report agrees the organisation can improve aspects of its service delivery at the service. Following the initial visit in December 2023, the service was completing weekly time sensitive medication reports. While improvements were noted, the Approved provider has noted that the reports were not individualised enough to ensure adequate reporting of incidents or to identify areas for improvement. The Approved provider has refined reporting processes whereby daily time sensitive medication administration reports are completed for each consumer which are forwarded to management. Incident reports are then completed by the Registered nurse responsible for the medication error within 24 hours of the incident occurring. The Approved provider submitted a report which included the identification of 27 instances between 19 March 2024 and 02 April 2024, where medication had been administered outside 30 minutes of the prescribed timeframe. The report included information to support a medication incident had been completed for each occasion.

For seven consumers identified as having medication incidents relating to time sensitive medication, bulk incident reports were retrospectively reported. The Approved provider stated open disclosure processes were followed and the named consumers’ next of kin were notified. The Comprehensive report completed for the retrospective incidents contains corrective actions including communication to Registered nurses, time sensitive medication to be administered by Registered nurses and double signed.

I note the Comprehensive reports indicate the initial and actual severity of the medication incidents are rated as minor, this is despite meeting minutes recorded 20 March 2024 note that for three consumers, the incorrect administration of time sensitive medication may have been a contributing factor to them experiencing falls.

The Assessment contact report includes information that management at the service had not identified any occasions when the late administration of time sensitive medication had met the threshold for reporting to the Serious incident response scheme, as incidents had not been recorded. Now I note that despite incidents being actively and retrospectively recorded, the Approved provider has not documented in its response that these medication incidents have been reported to the Serious incident response scheme, despite the definition for reportable incidents of neglect include the failure to administer correct or time critical medications. I note the Plan for continuous improvement indicates education is needed for Registered nurses relating to medication incident reporting and the Serious incident response scheme. I also note the planned completion for this action is 30 April 2024, and no outcome is listed in the Plan for continuous improvement.

In coming to my decision regarding compliance in this Requirement I have considered the Assessment contact report alongside the Approved provider’s response. It is my decision improvement actions have not been embedded sufficiently or evaluated for sustainability, to address the non-compliance in this Requirement. It is particularly concerning this Requirement has been non-compliant since December 2023 and the service’s Plan for continuous improvements notes that staff responsible for the administration of time sensitive medication are not always aware of the importance of time sensitive medication.

Therefore, it is my decision this Requirement remains 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)