Performance

Report

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| Name of service: | Frank Prendergast House |
| Service address: | 27 Pearson Drive SUCCESS WA 6164 |
| Commission ID: | 7255 |
| Approved provider: | Southern Cross Care (WA) Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 July 2023 |
| Performance report date: | 25 August 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 Frank Prendergast House (**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.

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 - 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 31 July 2023;
* the performance report dated 21 February 2023 for the Assessment Contact-Site undertaken 10 January 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 8** **Organisational governance** | Non-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 3 Requirements (3)(a) and (3)(b)**

* Ensure consumers are provided clinical care which is best practice and meets their needs and preferences, specifically in relation to management of pain and wounds.
* Ensure consumers’ high impact or high prevalence risks are effectively managed, including risks associated with changed behaviours impacting other consumers.

**Standard 8 Requirement (3)(d)**

* Effective risk management systems and practices supporting staff to proactively identify, assess and mitigate risks. Ensure the service effectively implements and applies the organisation’s risk management framework.

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

Findings

The service was found non-compliant with Requirement 3(3)(a) following a Site Audit in May 2022 and an Assessment Contact in January 2023. At this Assessment Contact, the Assessment Team assessed Requirements 3(3)(a) and 3(3)(b) and have recommended them as not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement 3(3)(a)**

Requirement 3(3)(a) was found non-compliant following an Assessment Contact in January 2023 where it was found one consumer who had a history of declining assistance did not receive assistance with personal care to optimise their health and well-being and the service could not demonstrate strategies had been tried to assist the consumer to manage their personal hygiene.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Staff training in behaviour management.
* Appointment of a dementia consultant.

At the Assessment Contact in July 2023 the Assessment Team recommended Requirement 3(3)(a) as not met and found, whilst improvements have been implemented, four consumers did not receive safe and effective clinical and personal care that is best practice, specifically in relation to the management of changed behaviours, continence and wounds. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer A experienced changed behaviours and was showing physical aggression and agitation when staff were attempting to provide assistance with personal hygiene and wounds management. The consumer’s wounds became infected and impacted on the consumer’s mobility. Wound charts did not show weekly photographs to assist with wound monitoring as directed by the organisation’s policy.
* Wound charts for 2 other consumers with wounds and pressure injuries did not show weekly photographs and measurements as directed by the service’s policy.
* Consumer B’s pressure injury has not resolved in 10 months.
* Consumer C’s bowel chart showed no bowel movement recorded for 7 days. The consumer was administered medication to promote bowel movement over three days and a general practitioner reviewed and changed the consumer’s medication to improve bowel movement. Whilst it was documented in the progress notes that the consumer responded to interventions and opened their bowels, this was not reflected on a bowel chart and there was no evidence of a plan of further escalation nor abdominal examination undertaken in the consumer’s care records.

The provider does not agree with all the findings in this requirement and have included further information in relation to this requirement that they believe would address the recommendation of not met. This information and improvement actions include, but are not limited to:

In relation to Consumer A:

* Through the implementation and review of pharmacological and non-pharmacological strategies over the past 3 months, it can be seen in the Activities of Daily Living (ADL) and progress notes that staff were successful in providing the consumer assistance with showering and wound dressings. This improved compliance seems to correlate with medication changes and the significant multidisciplinary inputs from internal and external service providers and specialists.

In relation to wounds’ measurement and photographs:

* Clinical staff have been provided the wound procedure, support, and training. Photographs are now being taken in accordance with the procedure, at least weekly.
* Consumer C receives services from an external service provider up to 3 times a week for 4 to 6 hours at a time. There is a pressure and continence plan for these outings.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 3(3)(a).

I find the service does not demonstrate each consumer receives safe and effective personal and clinical care that is tailored to their needs or optimises their health and well-being. I have placed weight on the evidence in relation to clinical care provided to Consumer A and B, specifically in relation to pain, changed behaviours and wound management.

I have considered Consumer A’s pain management was not effective, not tailored to the consumer’s needs and contributed to ongoing refusal of wound care, deterioration of the wounds and infection.

In coming to my finding in relation to Consumer A, I have considered information in the provider’s response, including Consumer A’s medication chart and records of medications administered on an as required basis. The evidence shows strong analgesia was prescribed in February 2022 with instructions to be given when required for pain/wound care. In addition, a report following a review of the consumer’s ongoing changed behaviours by an external service provider dated March 2023 shows one of the contributing factors to the consumers’ changed behaviours included pain. The report records the consumer was in severe pain at the time of assessment, however the above-mentioned medication was not being administered despite being prescribed and available to staff for administration.

Furthermore, medication administration records show staff started to trial routine administration of this medication prior to wound care and showering only from late June 2023. I consider the consumer’s pain was not managed effectively for several months as medication prescribed to be administered for pain and wound care was not administered/ trialled.

I find Consumer B did not receive safe and effective clinical care that is tailored to their needs, specifically in relation to the management of a pressure injury and continence care. Whilst the provider states in its response the consumer is going out regularly for an extended period of time and provides a support plan outlining strategies for pressure care, positioning and continence assistance, I note this plan was completed after the Assessment Contact. The provider did not provide evidence of how they ensured Consumer B’s care needs, including around pressure area care and continence care were managed when the consumer was going on extended outings prior to this. Finally, I considered Consumer B’s care was not effective because the pressure injury failed to heal for over 10 months.

I consider Consumer C’s management of constipation was timely and effective. Whilst the Assessment Team found no evidence of bowels opened over 7 days on a bowel chart, it was recorded in progress notes. I have also considered nursing staff escalated their concerns to the general practitioner in a timely manner resulting in a review and an increase of medications to aid bowel movement. Evidence in the provider’s response shows interventions were effective and resulted in resolution of constipation.

I acknowledge the provider’s response and actions taken following the Assessment Contact to ensure nursing staff compliance with measuring and photographing of wounds in line with the organisation’s policies.

For the reasons detailed above, I find Requirement 3(3)(a) non-compliant.

**Requirement 3(3)(b)**

The Assessment Team recommended Requirement 3(3)(b) as Not Met because they found the service does not effectively manage high impact or high prevalence risks associated with hydration, pain and changed behaviours. The Assessment Team’s report provided the following evidence relevant to my finding:

* The service did not demonstrate the management of pain was considered as a primary factor influencing Consumer A’s changed behaviours. Whilst the consumer was prescribed and administered antipsychotic and sedative medication in order to support staff to perform wound care, this was not effective, and the consumer continued to display agitation and physical aggression when the staff approached them to attempt wound care. In addition, the care plan records did not evidence consideration of the increasing use of psychotropic medication as a falls risk. Consumer A sustained one fall requiring hospital transfer.
* In response to a change to Consumer D’s condition, a hospital transfer was arranged. The consumer was diagnosed with dehydration. Risks of dehydration were not reflected in the consumer’s care plan and a fluid balance chart commenced on return from hospital was not consistently completed. The consumer’s representative advised they are visiting daily to ensure staff provide adequate hydration and assistance.
* Whilst the service has implemented strategies to manage the changed behaviours of Consumer E, these strategies have not been evaluated for effectiveness resulting in ongoing episodes of intrusive wandering daily for the period of at least 20 days. One consumer advised they do not feel safe and feel they need to lock their rooms doors to prevent Consumer E from entering their room.

The provider does not agree with all the findings in this Requirement and have provided further information in relation to this requirement that they believe would address the recommendation of not met. This information and improvement actions include, but are not limited to:

* Consumer A has been reviewed by both the physiotherapist and occupational therapist for falls risk strategies and pressure area care. Strategies are in place to minimise their risk of falling and they are being monitored closely by the allied health, clinical and care staff.
* Consumer D’s vital signs prior to hospital transfer were normal. Bowel, weight chart and progress notes do not indicate fluid loss or inadequate oral intake. Assessment was completed and there was no evidence of dehydration and subsequently their fluid chart was ceased. Staff reported Consumer D was eating and drinking well and continues to not show any evidence of dehydration.
* In relation to Consumer E, Sighting charts, signs on doors, redirection, and engagement in activities are all strategies in place to manage Consumer E’s changed behaviours.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 3(3)(b). I find the service does not effectively manage risks associated with the ongoing changed behaviours of one consumer. In coming to my finding, I have placed weight on evidence in relation to Consumer E and another consumer’s feedback that they do not feel the service manages changed behaviours of Consumer E effectively.

I have considered evidence in the provider’s response showing Consumer E was reviewed by a Dementia Consultant after the Assessment Contact who acknowledged staff concerns of Consumer E’s increasing intrusiveness with complaints made by other consumers. The consultant has offered a range pf pharmacological and non-pharmacological interventions to trial.

I acknowledge the proactive approach from the provider in response to the findings in the Assessment Team’s report. However, I considered information in behaviour charting attached to the provider’s response completed by staff over 20 days following the Assessment Contact. A review of the behaviour charting shows whilst incidents of changed behaviours were not frequent, they are impacting other consumers because Consumer E was still entering other consumers rooms at night disrupting their sleep.

I considered Consumer A’s pain was not managed effectively and subsequent refusals of wound care contributed to a wound infection. I find the provider failed to demonstrate they provided tailored clinical care to the consumer taking into account the consumer’s pain management needs. I have considered evidence in relation to Consumer A’s personal and clinical care and the provider’s response under Requirement 3(3)(a).

In relation to the management of Consumer A’s falls risk, I consider the provider did not provide evidence showing staff implemented falls prevention strategies following an increase in psychotropic medications that is one of the risk factors that could have been addressed.

I consider the provider manages risks associated with hydration effectively. Whilst I accept Consumer D was diagnosed with dehydration and fluid balance chart was not consistently completed on the consumer’s return, I have considered information and evidence in the provider’s response showing there was no indication the consumer was not provided sufficient hydration. Whilst the consumer’s representative advised they come to the service to ensure Consumer D is provided assistance with fluids, the representative did not provide any examples of when such assistance was not provided.

For the reasons detailed above, I find Requirement 3(3)(b) 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. | Non-compliant |

Findings

The Assessment Team recommended Requirement 8(3)(d) as Not Met because they found risk management systems and practices are not effective in relation to managing high impact or high prevalence risks associated with the care of consumers. The service does not consistently identify, monitor, or manage consumers’ risk, nor effectively analyse risk data, to ensure mitigating strategies are in place. The Assessment Team’s report provided the following evidence relevant to my finding:

* Management did not provide evidence of monthly clinical incidents analysis and actions.
* While staff support consumer’s choice to lock their doors for privacy, the service has not undertaken risk assessments to identify potential risks of harm to consumers and to provide mitigating strategies to manage these risks.
* The Assessment Team identified the service did not have documented mitigating risk strategies for all consumers who choose to lock their doors at night time.
* Some consumers were using plastic chains across their doors to keep other consumers out of their rooms. No risk assessments were provided for the use of these chains.
* The service did not effectively manage the risks associated with the changed behaviour of one consumer who wanders. This had resulted in one consumer reporting he felt his rights and wellbeing were being impacted.
* Consumer risk reports can be obtained from the service’s electronic care record, however, this had not been successful in enabling senior clinical management to have oversight and to monitor the delivery of care to Consumers A, B, C, D and E identified with high impact high prevalence risks, such as dehydration, pain, pressure injury and wounds.

The provider does not agree with all the findings in this Requirement and have provided further information in relation to this requirement that they believe would address the recommendation of not met. This information and improvement actions include, but are not limited to:

* There are multiple mechanisms in place to effectively manage high impact and high prevalence risks, including through analysis of clinical incidents data, weekly clinical risk meetings, monthly Quality Indicators report and home management meetings.
* Ongoing monitoring for high frequency and high impact incidents is an essential aspect to the governance process which have been strengthened within the last 7 months through creating new position of General Manager or Wellness, Mental Health Registered Nurse and Dementia Consultant.
* Consumers have a right to privacy and are permitted to lock their doors if they wish. All doors can be opened from the inside, even when locked, preventing a consumer from accidentally locking themselves or others in a room. Consumers who wish to lock their doors when they leave their room are either given a key (if they can use one) or they can ask staff to lock the door for them. Staff have a master key and can unlock all doors. This approach is aligned to the organisation’s shared decision-making framework and if there was a risk that was not mitigated by the above, additional mitigation actions would be included on the dignity of risk.
* Dignity of risk forms have been completed since the Assessment Contact for consumers who choose to lock their doors at night.
* There is an organisation-wide plan to remove door chains.
* A discussion regarding the risks associated with having a door chain have been held with the consumer who chose to keep a chain and a dignity of risk form has been completed.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 8(3)(d).

I find whilst the Assessment Team’s report shows effective risk management systems and practices, in relation to identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents, not all risks are identified, and mitigation strategies are not put in place in a timely manner.

The service did not demonstrate it effectively implements and applies the organisation’s risk management processes. The service did not identify and action ongoing deficits in the management of consumers’ high impact and high prevalence risks, resulting in consumers having pain and deteriorating wounds.

I acknowledge the provider’s response and supporting documentation, such as the Secure Door policy that provides a framework for supporting consumers rights, dignity and to ensure consumers privacy is respected. I acknowledge evidence of discussion for two consumers in relation to risks associated with their choices to have chain across their doors or to carry a key for their room and to lock it.

However, I note documented evidence shows these discussions occurred following the Assessment Contact visit and risks mitigation strategies were not recorded on one of the Dignity of Risk Assessment and Management Plans despite showing high risk of harm associated with the consumer’s choice, such as physical injury requiring medical treatment.

I accept the organisation has a plan to remove all door chains. However, I consider the intent of this requirement is to ensure that an organisation proactively identifies, assesses, and mitigates risks. Whilst the service identified risks associated with the chain doors, it did not provide evidence of what measures, if any, were put in place to mitigate the risks.

For the reasons detailed above, I find Requirement 8(3)(d) non-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)