Performance

Report

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| Name of service: | Hills Mallee Southern Aged Care Facility |
| Service address: | Parker Street MANNUM SA 5238 |
| Commission ID: | 6178 |
| Approved provider: | Riverland Mallee Coorong Local Health Network Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 November 2022 |
| Performance report date: | 22 December 2022 |

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 Hills Mallee Southern Aged Care Facility (**the service**) has been prepared by M Glenn, 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 consumers, representatives, staff, management and other;
* the provider’s response to the assessment team’s report received 6 December 2022; and
* the Performance Report dated 12 April 2022 for a Site Audit undertaken from 21 February 2022 to 23 February 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **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 2 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to initiate charting and assessments, develop and/or update care plans, and regularly review consumers’ care and service needs.
* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review, specifically pain management, are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review, specifically pain.

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

* Ensure staff have the skills and knowledge to undertake appropriate assessment and review of wounds and document detailed outcomes to enable effective monitoring of wound progression.
* Ensure policies, procedures and guidelines in relation to wound management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to wound management.

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

* Review the organisation’s risk management systems and practices relating to managing high impact or high prevalence risks, specifically pain and wound management.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where it was found each consumer was not supported to take risks to enable them to live the best life they can. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Held a discussion regarding risks with the family of a consumer, highlighted in the Site Audit report, signed a dignity of risk form and documented risk management strategies in the care plan.
* Embed processes, in line with newly developed procedures, to enable consumers to live the life they choose.
* Developed a Dignity of risk and duty of care procedure.
* Reviewed and updated Dignity of risk forms for all consumers on modified diets.

At the Assessment Contact undertaken on 17 November 2022, it was found the service has considered a range of activities deemed to incorporate an element of risk and associated risk assessments showed consumers have been involved in this process, including explaining the risks involved and strategies to minimise those risks. Allied health professionals are involved in assessing risk and in the review process.

For the reasons detailed above, I find Requirement (3)(d) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirements (3)(a) and (3)(e) were found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where it was found:

* assessment and planning processes did not effectively inform the delivery of safe and effective care and services, specifically in relation to infection reports, pain and behaviours; and
* care and services were not regularly reviewed for effectiveness, specifically in response to incidents impacting on the needs, goals or preferences of consumers.

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

* Reviewed policy documents and convened a working party with the purpose of developing work instructions to more clearly outline documentation requirements.
* Reviewed all consumers with infections and updated care plans to reflect infection status and personal protective equipment requirements.
* Updated care plans and pain assessments, and the effectiveness of medication is now documented on the electronic system and reviewed daily.
* Completed comprehensive behaviour assessments and behaviour support plans.
* Conducted daily reviews of progress notes for a two-week period and spoke directly with staff, where required, to provide additional learning and development.
* Introduced huddle meetings to reinforce learning on a variety of topics, such as falls and wounds.

The Assessment Team recommended Requirement (3)(e) met. However, in relation to Requirement (3)(a),the Assessment Team found while some actions had been taken and improvements were observed to be embedded into care in relation to infection risks, the service did not demonstrate pain assessments and charting informed care and services and recommended Requirement (3)(a) in Standard 2 not met. The Assessment Team provided the following evidence and information collected through interviews and documents which are relevant to my finding:

* Two consumers had been commenced on a trial of as needed opioid pain relief following signs of increased pain. Whilst five day pain charts were documented prior to the trial, pain had not been charted or assessed following commencement of the trial. Where the medication was administered, staff had inconsistently documented its administration in progress notes and had not included indication or effectiveness of the medication. For example:
* Consumer A was prescribed as needed opioid pain relief on 24 August 2022 for three months following increased signs of pain and agitation. Administration for a trial period was not commenced until 14 November 2022. Pain charting was only evident between 3 to 7 November 2022 and had not been used to record episodes of pain or include indication or effectiveness of interventions. The medication had been administered on four occasions in November 2022, between the 14 and 17. There were only two progress notes for November 2022 indicting the medication had been administered, of which one entry stated the reason. Evaluation of pain interventions has not been undertaken.
* A respite consumer who entered the service six days prior, had not yet been assessed for pain as part of initial assessment processes. While the consumer said they were not in pain, clinical staff said pain should be included in initial assessments for respite and permanent consumers.

The Assessment Team’s report also highlighted evidence relating to policies and procedures to guide assessment and planning processes. I find this evidence more aligned to Standard 8 Organisational governance Requirement (3)(d) and, as such, I have considered this evidence and the provider’s response in my finding for that Standard and Requirement.

The provider did not dispute the evidence outlined in the Assessment Team’s report. The provider’s response consisted of a Plan for continuous improvement, directly addressing the deficits highlighted in the Assessment Team’s report, and outlined planned actions, timeframes and outcomes. The provider’s response included, but was not limited to:

* Implementing an Admission schedule for new residents. The document, included as part of the provider’s response, includes commencing a daily form for pain on entry for a one-month period, and to continue if pain is present.
* Administration of as required medication to be monitored daily and pain assessments reviewed.
* Audits to be conducted on all new admissions to ensure completion of pain assessment and charting.

I acknowledge the provider’s response. However, I find at the time of the Assessment Contact, assessment and charting, specifically in relation to pain management, was not effectively undertaken to ensure assessment and planning was personalised and reflective of consumers’ current needs. I have considered that this has not ensured each consumer’s care plan is tailored to their specific needs or informs how, for each consumer, care and services are to be delivered.

For two consumers highlighted, pain charting and assessments were not initiated in response to a trial of as needed opioid pain relief, commenced following signs of increased pain. Whilst the three month trial commenced in August 2022, pain charting for Consumer A was only evident for a five day period in November 2022, and had not been used to record episodes of pain, indication for use or effectiveness of interventions initiated. Additionally, evaluation of pain interventions had not been undertaken. I have also considered that while a respite consumer did not indicate they were experiencing pain, pain assessments had not been completed, in line with the service’s processes to inform care and service needs and preferences. As such, I find this has not ensured risks to consumers’ health and well-being are identified to enable appropriate management strategies to be developed or that staff have the required information available to them to guide delivery of care and services, in line with the consumers’ care and service needs and preferences.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

In relation to Requirement (3)(e), care and services were found to be reviewed on a rolling six monthly cycle and as required, with the service confirming all care plans are up-to-date. Care plans sampled demonstrated updates had occurred when consumers’ circumstances had changed, such as weight loss, skin integrity, wounds and risks associated with mental health and well-being. Staff described how and when to lodge incidents, such as post falls, and processes for documentation, monitoring and medical oversight. Consumers and representatives confirmed the care plan review process and stated regular reviews of consumers’ care and service needs occur.

For the reasons detailed above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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 |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where it was found the service had not ensured each consumer was provided safe and effective personal and/or clinical care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to wound management and diabetes. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Conducted education sessions with staff, including in relation to skin and wound photography and diabetes, and introduced huddles as an education tool.
* A ‘Treatment of hypoglycaemia in people with diabetes in aged care’ clinical protocol and hypoglycaemia flowchart were made available to staff.
* The Medical officer reviewed all diabetic management plans, including target ranges, and included clearer instructions.
* Reviewing progress notes daily to ensure care and documentation meets expected standards.

However, the Assessment Team found while actions have been taken and improvements were observed to be embedded into care in relation to diabetes, the service did not demonstrate wound management is best practice or optimises consumers’ health and well-being and recommended Requirement (3)(a) not met. The Assessment Team provided the following evidence and information collected through interviews and documents which are relevant to my finding:

* Size and dimensions of Consumer B’s pressure injury have not been consistently recorded in the wound/skin management plan. Photographs of the wound are blurry, infrequently taken, do not consistently include a ruler to indicate size and do not enable accurate indication of healing status. Photographs of the wound have not been taken since 23 August 2022 and staff have not documented whether the wound is improving.
* There are no measurements of Consumer C’s wound documented in the wound/skin management plan. All photographs are blurred and do not provide an accurate assessment of the healing status and of the 19 photographs taken in 2022, a ruler has only been included in seven of them.
* Clinical staff understanding of the frequency of wound photography was inconsistent.

The Assessment Team’s report also highlighted evidence relating to policies and procedures to guide staff practice and a wound management audit. I find this evidence more aligned to Standard 8 Organisational governance Requirement (3)(d) and, as such, I have considered this evidence and the provider’s response in my finding for that Standard and Requirement.

The provider did not dispute the evidence outlined in the Assessment Team’s report. The provider’s response consisted of a Plan for continuous improvement, directly addressing the deficits highlighted in the Assessment Team’s report, and outlined planned actions, timeframes and outcomes. The provider’s response included, but was not limited to:

* Wound management to be monitored daily, following up weekly photographs and quality of same.
* Allocating staff daily to attend wound care allowing staff to be held to account.
* Initiating a Podiatrist referral for Consumer B with a view of providing a more comprehensive report and guidance for healing and referrals to a Diabetic educator and Dietitian.

I acknowledge the provider’s response. However, I find at the time of the Assessment Contact, the service did not ensure each consumer was provided safe and effective clinical care that was best practice and optimised their health and well-being, specifically in relation to wound management. In coming to my finding, I have considered that for consumers highlighted, wounds were not adequately reviewed or assessed, with dimensions of wounds not consistently documented. Additionally, wound photographs have not been consistently taken, and all photographs sampled were blurred. I find that the lack of detail in wound/skin management plans and the poor quality of wound photographs does not enable staff to effectively monitor wound progression and appearance or ensure wound deterioration is identified in a timely manner and appropriate actions taken accordingly.

For the reasons detailed above, I find Requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where it was found the service had not ensured information about consumers’ condition, needs and preferences was effectively communicated. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed meal communication processes.
* Hardwired internet access into the kitchen to enable hospitality staff to access dietary needs reports which are checked prior to the preparation of every meal to ensure consumers’ current dietary needs and preferences are adhered to.
* Conducted surveys with all consumers to ensure food preferences are being met, documented and communicated.

At the Assessment Contact undertaken on 17 November 2022, information about consumers’ condition, needs and preferences was found to be communicated within the organisation, and with others where responsibility for care is shared. Information about consumers was reflected in care plans, assessments and progress notes sampled, and this information was found to be effectively communicated within the service through use of an electronic management system, as well as meetings and handover processes. Consumers’ identified needs and preferences, such as personal and family relationships, dietary requirements, clinical care needs that might impact the lifestyle program and preferences for the delivery of care and emotional care needs were known by staff. One consumer confirmed staff are aware of their medical condition and ensure they receive care, specifically meals, in line with their preferences.

For the reasons detailed above, I find Requirement (3)(d) in Standard 4 Services and supports for daily living compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement (3)(c) was found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where it was found appropriate action was not consistently taken in response to complaints, specifically verbal complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided education to staff, as well as verbal reminders communicated at meetings to ensure understanding of complaint handling processes and importance of documenting all complaints, including those received verbally.
* The Director of nursing undertakes informal feedback sessions with consumers. However, evidence of these occurring was not demonstrated as they have not been documented.

At the Assessment Contact undertaken on 17 November 2022, feedback, complaints and open disclosure policies and procedures were found to be available to guide management and staff practice. Staff sampled were familiar with complaint management and open disclosure principles and understood the importance of following this when things go wrong. Management and staff described the service’s complaints management process to gather, address and review feedback and most consumers and representatives, including those that were highlighted in the Site Audit report confirmed appropriate action is taken to address feedback and complaints and felt the service has a transparent approach when things go wrong. A Feedback register is maintained and includes both verbal and written feedback, and a data analysis and trending report outlines actions taken and how open disclosure was applied and allows trending of complaints and compliments to identify areas for improvement.

For the reasons detailed above, I find Requirement (3)(c) in Standard 6 Feedback and complaints 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

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 21 February 2022 to 23 February 2022 where effective risk management systems and practices, specifically in relation to managing and preventing incidents, including the use of an incident management system were not demonstrated. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to provided education to staff, as well as verbal reminders communicated at meetings to ensure understanding of the incident management process and importance of documenting all incidents as they occur.

At the Assessment Contact on 17 November 2022, the Assessment Team found systems and practices to manage, monitor and respond to high impact or high prevalence risks were not effectively demonstrated and recommended Requirement (3)(d) not met. The Assessment Team provided the following evidence and information collected through interviews and documents which are relevant to my finding:

* An incident report completed in July 2022 identified a consumer was prescribed a psychotropic medication without consultation, consent, or an aligned diagnoses. The representative was contacted and did not give consent for continued use; an apology was provided, and the medications ceased. The incident was not reviewed until September 2022, and was not reported under the Serious Incident Response Scheme (SIRS).
* Management said the medication was prescribed whilst the consumer was in hospital and they were discharged with the prescription. They were unable to ascertain if the medication was administered following return from hospital or provide clarification as to why this incident was not considered for reporting under SIRS.
* Wounds for two consumers have been identified on the high risk register, notating the location of the wounds, however, current interventions, strategies, the stage of the wound or effectiveness of current interventions were not noted.
* Clinical staff understanding of the frequency of wound photography was inconsistent and they were not aware of any policies or procedures to guide practice, stating they rely on their experience.
* Management provided a ‘pictorial guide of how to take wound photo’ factsheet and a step by step process on how staff document wounds on the electronic system. Whilst the latter document states staff are to upload an initial photograph, describe wound healing status and interventions, neither document guides staff on ongoing sizing and photography expectations.
* A wound management audit dated 31 August 2022 included Consumers B and C in the sample. All areas of wound care, including accuracy of assessments capturing all necessary information, photographic records taken (does not specify timeframe) and healing rate of the wound resulted in 100% compliance with the exception of using a ruler in photographs which has achieved a 0% result. The audit states staff will be reminded of the requirement, however, further actions taken in response were not demonstrated.
* Clinical staff were not aware of any policies or procedures to guide assessment and planning processes. Management said the organisation does not currently have policies or procedures specific to pain management and/or documentation processes.

The provider did not dispute the evidence outlined in the Assessment Team’s report. The provider’s response consisted of a Plan for continuous improvement, directly addressing the deficits highlighted in the Assessment Team’s report, and outlined planned actions, timeframes and outcomes. The provider’s response included, but was not limited to:

* In relation to the SIRS incident, the medication was commenced when the consumer was an acute patient. Medical officers were unable to contact family to consult with them, so the medication was commenced. The medication was listed on the medication chart when the consumer entered the service. A subsequent discussion with family indicated they did not want the consumer taking the medication and it was ceased.
* Development of wound management and specific aged care pain management guidelines.
* Indicated specific policies and procedures do exist to guide wound management practice and none of these require use of a ruler in photographs. Reference to the ruler is to be removed from the audit tool.
* High risk meetings to be refined to ensure comprehensive review of clinical risks, such as pain and wound management.

I acknowledge the provider’s response. However, I find at the time of the Assessment Contact, effective risk management systems and practices, specifically in relation to managing high impact or high prevalence risks associated with the care of consumers were not demonstrated.

In coming to my finding, I have considered insufficient guidance and ineffective monitoring processes have not ensured consumers’ clinical risks are effectively identified, monitored and/or assessed. Management confirmed the organisation does not currently have policies or procedures specific to pain management and/or documentation processes to guide staff practice. As highlighted in Standard 2 Requirement (3)(a), issues were identified in pain management, specifically assessment and charting. In relation to wound management, while I acknowledge the provider’s response indicating specific policies and procedures are available to guide staff practice, I have placed weight on feedback provided to the Assessment Team by staff which indicates they were not aware of these documents. Issues have been identified in Standard 3 Requirement (3)(a) relating to wound review and assessment.

I have also considered that the organisation’s own monitoring processes do not effectively identify trends relating to individual consumers or consider effectiveness of current management strategies with current interventions, strategies, wound staging or effectiveness of current interventions not identified on the high risk register. Additionally, a wound management audit undertaken in August 2022, which included two consumer’s highlighted in the Assessment Team’s report, resulted in a 100% compliance rating. As such, I find the service’s own monitoring processes have not been effective in identifying issues relating wound management practices, as highlighted by the Assessment Team.

In relation to SIRS reporting, I acknowledge the additional commentary included in the provider’s response and note the planned actions, including daily review of incident data and providing further training to senior management on SIRS.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance 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)