Performance

Report

**1800 951 822**

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| Name of service: | Hixson Gardens Aged Care Facility |
| Service address: | 1A Hixson Street BANKSTOWN NSW 2200 |
| Commission ID: | 1018 |
| Approved provider: | Arete Health Care (Bankstown) Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 10 January 2023 |
| Performance report date: | 08 February 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 Hixson Gardens Aged Care Facility (**the service**) has been prepared by M Buhagiar, 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 conducted 10 January 2023, 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 January 2023.
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site: Performance Report dated 1 April 2021 following Assessment Contact 02 February 2021, Non-Compliance Notice dated 23 October 2020 following Assessment Contact 26 August 2020; Performance Report dated 29 September 2020 following Assessment Contact 26 August 2020.
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances Determination dated 28 November 2022.

# 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.

* Requirement 3(3)(a) - The approved provider must demonstrate effective personal and clinical care with skin integrity, falls and pain management and the accurate identification and management of restrictive practices.
* Requirement 3(3)(b) - The approved provider must demonstrate there is effective incident management processes and systems to identify and mitigate high impact and high prevalence risks associated with the care of each consumer.
* Requirement 8(3)(d) - The approved provider must demonstrate there are effective risk management systems and practices, for the management of incidents and that there is effective organisational oversight with the analysis and review of risks and incidents.

# 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

During the Assessment Contact of 2 February 2021, the service was found to be non-compliant with these requirements due to gaps identified in areas of personal and clinical care including chemical restraint, pain management and skin integrity and several key high impact and high prevalence risks that are not effectively managed including falls management, and behaviour management. The service has initiated a number of improvements which were identified during this assessment contact on 10 January 2023. The Assessment Team acknowledge that the service has identified the need for improvements and has implemented some improvements to meet these requirements however at the time of the assessment contact, gaps were identified with the service not demonstrating effective personal and clinical care with skin integrity, pain management and restrictive practices and management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team found that most consumers or representatives are satisfied with the care and services provided and consider consumers receive safe and effective personal and clinical care.

Staff interviewed were able to describe how the assessment and care planning process results in safe and effective personal and clinical care to the consumers. However, review of documentation identified not all consumers had relevant assessments completed, which resulted in deficiencies in the identification of deterioration and there is not always effective monitoring or reviewing being completed.

For the consumers sampled the care documentation reviewed, and other information gathered, showed most consumers receive safe and effective personal and clinical care, which is best practice, tailored to their needs and optimises their health and well-being. However, gaps were identified in the identification and management of chemical restraint for sampled consumers, and wounds not being identified in a timely manner.

The organisation has policies and procedures that reflects best practice guidelines in the management of skin integrity, pressure injuries and wound management, however these policies and procedures are under review. For the sampled consumers care documentation reviewed showed not all wounds are well managed.

The organisation has policy and procedures that reflects best practice guidelines in the management of pain. However, for some sampled consumers it was not demonstrated that the organisation’s policies and procedures had been followed for effective pain management, monitoring or review.

The organisation has a policy relating to restrictive practice, which does not reflect regulatory obligations and best practice. The policy does not align with staff feedback regarding the timeframe for review of chemical restraints. See details under requirement 8(3)(d). The policy does not include individualised timeframes for review of restrictive practices.

The service was not able to demonstrate they followed the organisation’s policies and procedures around completing neurological observations after a consumer having an unwitnessed fall.

The Assessment Team found that the service is not able to demonstrate a robust incident management system or clinical monitoring system to identify high impact or high prevalence risk associated with the care of each consumer. In some instances, incident reports have not been completed after incidents or if they have been completed, they have not been followed up or closed out.

The service does not demonstrate appropriate monitoring following incidents. The Assessment Team identified details of neurological observations had not been attended following an unwitnessed fall. Behaviour triggers indicates there is a lack of staff understanding to identify triggers and behaviour support plans do not include non-pharmacological strategies to support changed behaviours.

The service did not provide evidence the clinical data is analysed, high risks identified, and actions taken to minimise risks associated with the care of each consumer. See further details under requirement 8(3)(d).

The approved provider responded to the Assessment Team’s report and advised that skin integrity and wound care is a high priority for improvement and has addressed many of the gaps in documentation and has implemented new software and implemented champions to undertake weekly skin inspection for all consumers. The service has revised policies to convey more explicit guidelines and clearer interpretation of best practice principles and an over-arching Medical Advisory Committee for the organisation to focus on governance and risk, including the review and development of policies and procedures.

Whilst I acknowledge the work that the management team has implemented since the last Site Audit and introduced since this visit, I understand that it will take some time to reflect compliance and demonstrate that the actions to address the gaps are sustainable. I find that the approved provider is non-compliant with requirements 3(3)(a) and 3(3)(b).

# 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

During the Assessment Contact of 2 February 2021, the service was found to be non-compliant with this requirement as the risk management system was not effectively applied in managing risk of harm to consumers, this includes the areas of falls management, management of pain, challenging behaviours, wounds, and minimising the risk associated with psychotropic medication use and restraint.

While the Assessment Team acknowledge during this assessment contact of 10 January 2023, the organisation has identified significant gaps in the effectiveness of the risk management systems and practices and is working towards improvements, the improvements have not had time to be either implemented or if implemented have not had time to be evaluated. The Assessment Team finds the organisation does not have effective risk management systems to manage high impact or high prevalence risk associated with the care of consumers, identifying and responding to abuse and neglect, supporting consumers to live their best lives and managing and preventing incidents.

The organisation is unable to demonstrate an effective incident management system. Incident reports are not always completed following incidents. Incident reports are not consistently completed, followed up or closed out. Data from incidents since June 2022 has not been collected for review and analysis.

The management team said weekly reporting of clinical data occurs between the management team and the approved provider weekly. The content of the discussions is not documented to demonstrate oversight at an organisational level.

The management team provided the Assessment Team with information to support the improvements underway such as a new internal auditing system to capture and analyse clinical data, and new terms of reference for governance meetings and a new meeting schedule, however these have not yet been introduced. The Assessment Team note the proposed audits do not align with the Quality Standards.

The service provided the Assessment Team with a pharmacy produced ‘psychotropic and drugs of interest usage/diagnosis’ report dated 1 December 2022. Information on the report did not align with the information provided by the service regarding chemical restraint. Recommendations within the pharmacy report have not been considered by the service.

Management informed the Assessment Team they have identified the organisational policies and procedures regarding risk management are not adequate. They said they are developing a new suite of policies and procedures which will be more specific to the organisation. These policies have not yet been implemented. Policies and procedures provided to the Assessment Team do not include the date they were written and do not include dates for review.

The approved provider responded to the Assessment Team’s report and advised of the improvements planned and the current mechanism for reviewing and analysing data during weekly huddles of the management team.

I have considered the information provided by the approved provider, however, acknowledge that the incident and risk management system is not effective in the provision of critical information to analyse and review high impact and high prevalence risks or incidents.

I find that the approved provider is non-compliant with this requirement.

1. The preparation of the performance report is in accordance with section 68A – assessment contact, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)