Performance

Report

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| Name: | Imlay House |
| Commission ID: | 2740 |
| Address: | 3 Merigan Street, PAMBULA, New South Wales, 2549 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 16 January 2024 to 17 January 2024 |
| Performance report date: | 20 February 2024 |
| Service included in this assessment: | Provider: 1515 Sapphire Coast Community Aged Care Ltd  Service: 1096 Imlay House |

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 Imlay House (**the service**) has been prepared by Katrina Platt, 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 on 8 February 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 8** Organisational governance | **Not applicable as not all requirements assessed** |

A detailed assessment is provided later in this report for each assessed Requirement.

# 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 ensures an ongoing commitment to continuous improvement which ensures each consumer receives both personal care and clinical care which is best practice, tailored to their needs and optimises their health and well-being. Effective and long-term implementation of the improvement measures highlighted in the action plan, and supported by the education plan, is also required to ensure the effectiveness of personal care and clinical care provision to all consumers, including for wound management, falls management, behaviour management, restrictive practices and pain management.

# 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. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |

Findings

Care documentation evidenced deficiencies in consumer wound management which contributed to consumer wound deterioration and delayed healing outcomes. Policies, checklists and duty statements were not consistently followed by staff and wound care policies lacked direction for staff practice. Clinical oversight of consumer wounds by staff and managers was inconsistent with wound policies, which included delayed wound assessment and reviews, inconsistent photography and measurements for wound monitoring and incomplete incident reporting.

Consumers received inconsistent pain management, with delayed assessment and monitoring of pain and alternate pain relief options not always offered. Care documentation evidenced neurological observations for one consumer was inconsistent with post-falls procedure and abnormal observations were not escalated for medical officer review.

Behaviour support plans were not always evidenced for consumers with recorded behaviours and behaviour support interventions for staff guidance were generic, limited and in some cases not documented. Behaviours of concern were not always recorded and delayed referrals to Dementia Support Australia for intervention management contributed to repetitive behaviours and increased impacts on consumers.

Consumers prescribed chemical restraint were not always recorded on the psychotropic register and informed consent was not always obtained, and not regularly reviewed. Staff did not consistently demonstrate sufficient knowledge about restrictive practices, including restraint definitions and their differences.

In response to the Assessment Team report, the Approved Provider undertook comprehensive reviews of all consumers and their care plans to ensure safe and effective care and services was being provided. The action plan submitted for consideration detailed implementation of daily huddle meetings with senior staff to foster improvements in communication and reporting, and staff education on system alert processes with daily oversight to ensure processes are embedded. Daily management meetings monitor and review implementation of improvement actions and daily rounding provides additional oversight and staff contact. A draft education plan has been developed and an onsite education provider will be engaged to assist with its delivery.

Full skin assessments and wound reviews were undertaken for all consumers, with all records updated and follow-up reviews scheduled for consumers with identified wounds after engagement with a wound consulting service. Consumer representatives were engaged in all consumer review processes. Additional wound care management and oversight will commence from March 2024 on engagement of a clinical nurse consultant to facilitate consistent wound review. The wound management policy has been updated and incorporates flow charts with regular and escalation pathways and a wound care roles and responsibilities guide has been developed and circulated to staff, with copies situated throughout the service for ongoing reference. Toolbox talks and wound competencies for staff were completed and ongoing education planned for skin integrity, wound management and dressings. All wounds are reviewed daily by the registered nurse and care manager, with subsequent weekly reporting to the chief operating officer for improved clinical governance.

The Approved Provider acknowledged the inconsistencies in pain management documentation, and noted detailed pain assessments and reviews were conducted for all consumers in accordance with their action plan. Consumer pain management is reviewed daily during staff huddles and by the registered nurse and care manager, and weekly review occurs incorporates the chief operating officer. Staff education on pain assessment and pain management will also be conducted through face-to-face sessions and toolbox talks.

All consumers will undergo behaviour review, with consumers who have behaviours of concern prioritised and behaviour support plans developed through the new electronic care system. Dementia Services Australia were engaged to conduct reviews for 3 consumers and their recommendations have been incorporated into all consumers’ care plans, with additional review to occur on receipt of the final report from Dementia Services Australia. Registered nurses have received education material and training related to the updated behaviour support plans, and staff will also receive additional training.

The Approved Provider acknowledged the falls management policy and post-fall care procedures were not followed for a consumer identified in the Assessment Team report. A post-fall incident review has occurred and the consumer representatives engaged for the purposes of open disclosure. Staff education and training has been scheduled, which includes post fall management and review of the post-falls management process.

The Approved Provider submitted an updated psychotropic register for consideration and confirmed informed consents were reviewed with consumer representatives for all consumers receiving chemical restraint. The clinical manager duty statement has been updated to incorporate responsibility for the weekly review and update of the chemical restraint register. For other restrictive practices, reviews conducted identified there were no consumers under other restraint mechanisms including mechanical restraint.

I am satisfied the Approved Provider has undertaken appropriate review of care and services deficiencies identified in the Assessment Team report and sought appropriate external support from organisations like Dementia Support Australia where required. Policies, procedures, roles and responsibilities have been reviewed to improve oversight of consumer wounds and skin integrity, and engagement of a wound care consultant to provide care and services directly to consumers ensures improvements in staff practices are additionally supported and embedded.

The action plan and training plan submitted is suggestive of a commitment to improvement in consumer care and services provision, as are the many actions taken by the Approved Provider in managing the identified issues. Changes to staff practice and responsibilities, however, will take time to embed within the service and impact on the effectiveness of consumer care and service provision, which reflects best practice, is tailored to consumer needs and optimises the health and well-being of every consumer. As such I find Requirement 3(3)(a) is not compliant.

Consumer deterioration or changes in their mental health, cognitive or physical function, capacity or condition were recognised and responded to in a timely manner. Care documentation evidenced timely identification and medical officer review and communication with consumers and consumer representatives. Staff were knowledgeable about recent consumer deterioration and described associated changes to care and services provision for individual consumers. Staff confirmed their participation in education on consumer deterioration.

# 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. | Compliant |

Findings

The documented risk management framework contained detailed guidance and policies for strategic risk management at both the organisational and service level, and included the governing body responsibilities relating to risk management overall. Evidence of internal systems and practices evaluation by the governing body was not demonstrated.

Management of high-impact and high-prevalence risks was demonstrated at organisational level, with multiple risk domains including consumer care, infection control and clinical governance identified and considered at management and board level. Deficiencies in staff guidance at service level impacted high-impact and high-prevalence risk management, with delayed risk identification, treatment and timely incident reporting contributing to poor consumer outcomes and ineffective risk management evaluation.

Organisational policies and procedures were evidenced for identifying and responding to consumer abuse and neglect and Serious Incident Response Scheme reporting. Staff were knowledgeable about key abuse definitions and escalation protocols, however were unfamiliar with the guidelines pertaining to recognising, escalating and reporting consumer neglect. Whilst policies and procedures were evident, their effective implementation was not demonstrated at a service level which contributed to deficiencies in consumer abuse and neglect identification, investigation, risk mitigation and prevention and legislative reporting.

Consumer well-being and living the best life they can was supported by policies and procedures and consumers and consumer representatives were encouraged to provide input into their care and services and provided information to the board through consumer forums. However, the deficiencies in care and service delivery as discussed in Standard 3 demonstrated consumer health and well-being were not effectively prioritised, monitored or managed.

Incident management and prevention policies and procedures were demonstrated, however were not always adhered to and impacted consumer health and well-being. Inconsistent and incorrect incident reporting in the electronic incident management system contributed to delays in consumer clinical reviews and consumer impacts were evident in wound management, pain management, behaviour management and falls management as discussed in Standard 3. Incident prevention strategies were not identified through root cause analysis and corrective actions were delayed.

In response to the Assessment Team report, the Approved Provider expressed confidence in their clinical governance framework and noted the governance subcommittee reviewed the service risk register in response to non-adherence with risk policies and procedures, with a copy of the risk register supplied for consideration. Additionally, the action plan notes the chief operating officer has been providing daily governance oversight support, with daily updates provided to the chief executive officer on action plan progress and whole of service clinical governance meetings have been also implemented on a weekly and monthly basis.

Deficiencies in comprehensive oversight were acknowledged by the Approved Provider, with staff performance management undertaken and further staff education on use of the incident management framework and individual roles and responsibilities identified and included in the education plan. Registered nurses have received additional resources and education to improve identification and responsiveness to identifying reportable incidents under the Serious Incidents Response Scheme, particularly consumer neglect. The new educational consultant will assist with

Improvements in the electronic ‘LeeCare’ system are being identified for incident management, which will enhance staff familiarity with reporting process already established and identify any upgrades required. Consumer incidents identified by the Assessment Team were reviewed and discussed with consumer representatives, with copies of incident reports submitted for confirmation. The action plan identifies clinical reviews for all consumers have been undertaken, and subsequent review of all incidents and risk analysis by the chief operating officer, and by the board governance subcommittee.

The Approved Provider expressed their commitment to supporting consumers to live the best life they can. They discussed their regular and ongoing engagement with consumers and consumer representatives at monthly meetings, leadership walk arounds, the compliments and complaints process and the ‘red letterbox’ for consumer feedback and suggestions. Regular communication with consumers occurs through regular service updates, and feedback from consumers is actively sought through the monthly moving-on audit process.

I acknowledge the actions taken by the Approved Provider in addressing the service-level deficiencies and the remedial actions taken to ensure the ongoing connection and collaboration between service-level and organisational-level governance, particularly for clinical governance. Improvements in staff practice have been demonstrated in incident management, with the noted oversight at board and subcommittee level which supports the maintenance of effective risk management systems and practices. I note the actions undertaken by the Approved Provider, as noted in the action plan and training plan submitted, and the commitment made to ongoing compliance with the Quality Standards. I therefore find Requirement 8(3)(d) is 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)