Performance

Report

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| Name: | Jindalee Aged Care Residence |
| Commission ID: | 2988 |
| Address: | 277 Goyder Street, NARRABUNDAH, Australian Capital Territory, 2604 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 3 September 2024 |
| Performance report date: | 30 October 2024 |
| Service included in this assessment: | Provider: 1158 Johnson Village Services Pty Ltd  Service: 1210 Jindalee Aged Care Residence |

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 Jindalee Aged Care Residence (**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 20 September 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not Applicable** |
| **Standard 7** Human resources | **Not Applicable** |

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 best practice is applied for wound management and neurological observations are observed for appropriate post-falls management. The approved provider ensures comprehensive assessments are undertaken for behaviour support and restrictive practices are used in accordance with the legislative requirements, including for chemical restraint and mechanical restraint.

# 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 |

Findings

Consumer weight loss management included regular consumer reviews, individual consumer meal modifications and referrals to dieticians and medical officers when required. Consumers with diabetes were regularly monitored and care and services documentation confirmed optimal management based on individual consumer needs. Care and services documentation recorded wound healing and appearance, however wound measurements were not captured with wound photography in accordance with the service policy.

Consumers with mobility needs experienced delayed referrals to allied health professionals which impacted health and well-being. Neurological observations were inconsistently recorded for consumers who experienced falls and staff were inconsistent in their knowledge of when observations should occur. Consumers with a high-risk of multiple falls were referred to physiotherapists and medical officers and falls incidents were investigated for risk mitigation purposes.

Behaviour support plans were not tailored to individual consumer needs and lacked detailed descriptions about changed behaviours, known triggers and underlying causes, and alternate behaviour supports and interventions. Restrictive practices were not used in accordance with legislative requirements. Evidence of chemical restraint monitoring, review of medication effectiveness and consideration as the last resort option was not demonstrated. Mechanical restraint was used without comprehensive behaviour assessment or recognition that use of a particular device was a mechanical restraint. Consideration of specialist involvement and alternative and less restrictive options to the mechanical restraint was not demonstrated.

In response to the Assessment Team report, the approved provider discussed changes to wound care practices including engagement of a new supplier. Adjustments to electronic assessment processes have been incorporated including (but not limited to) mandatory directive updates, wound dressing changes, exact measurement capture and mandatory wound photography. Education on accurate measurements, clear wound photography and electronic access to wound care information has been made available to staff.

A full review of all wounds has been undertaken by the director of nursing and the clinical care managers. Evidence of wound assessment completion was provided for consideration. The wound chart has been reviewed and best practice guidelines have been developed and provided to all staff. New skin integrity policies and procedures have been provided to clinical staff and are available at all work stations.

Mobility reviews have been completed by the physiotherapist and exercise programs implemented. Frequent reviews are occurring to assess the effectiveness of the implemented programs and consultation with consumers about needs and preferences has been undertaken and ongoing support is being provided, as necessary.

The approved provider acknowledged the electronic prompts for completion of neurological observations are not consistently adhered to. New falls management policies and procedures have been provided to clinical staff and are available at all work stations. The approved provider discussed engagement with the University of Canberra to consider best practice use and frequency of neurological observations following a fall and improvements to assessment outcomes.

For restrictive practices, the approved provider acknowledged that assessment documentation for administration of chemical restraint was not consistently completed. Evidence was submitted showing communication from the director of nursing to all clinical staff on 28 August 2024 reminding staff to complete assessments prior to administration of any ‘as needed’ medication and post-administration evaluation, and consideration of alternate non-pharmacological interventions. Evidence of geriatrician and specialist palliative care review, and ongoing engagement with consumer representatives to manage changed behaviours was also provided.

In response to the use of mechanical restraints, the approved provider discussed complex behaviour support and consideration of the least restrictive practices available to promote and protect consumer dignity, health and well-being. The approved provider confirmed alternate mechanisms are trialled and appropriate consents are obtained for use of mechanical restraints. The approved provider described the range of motion available to consumers who use mechanical restraints, which includes the ability to move around unrestricted. Regular 3-monthly reviews have been scheduled to ensure consumers are monitored and staff awareness is maintained about the ongoing use of restrictive practices. In summation, the approved provided disagreed with the concerns raised by the Assessment Team about the use of restrictive practices and submits the evidence provided supports satisfactory planning and action has been demonstrated.

In making a decision about Requirement 3(3)(a), I have considered the intent of the Requirement which sets the expectation that organisations provide safe and effective personal and clinical care to consumers which is guided by national best practice, tailored to meet their individual needs and optimises the health and well-being of consumers. Consumer well-being includes their physical and mental state, spiritual and emotional life, and social life. For the use of restrictive practices, I have also considered the *Quality of Care Principles 2014* (Cth) (‘Quality of Care Principles’) and the rights of consumers under the Charter of Aged Care Rights (‘Charter’).

The remedial actions undertaken for wound management reflect improvements in care delivery to consumers and wound care that meets national best practice. The provision of new skin integrity policies, procedures and guidance for staff, coupled with staff education and training, demonstrates a commitment to ensuring consumer wound care practice contributes positively to consumer health and well-being outcomes. As with all changes to staff practice, they take time to embed and reflect consistency in the approach to managing skin integrity and wounds.

The actions relating to mobility assessments are acknowledged, including ongoing assessment and reviews to ensure effective implementation of support measures. New falls management policies and procedures which incorporate guidance for neurological observations and staff communication avenues are also noted.

The measures discussed by the approved provider relating to neurological observations do not demonstrate any immediate actions are being taken to protect the health and safety of consumers who experience falls incidents. Electronic protocols for conducting neurological observations were not always followed, and there are no actions detailed in the response which show how the lack of monitoring and observations will be mitigated. Whilst some inference is drawn between staff understanding differences in the post-fall clinical presentation of consumers and the work to be completed with the University of Canberra, this does not address how neurological observations are being addressed in the shorter term, other than for clinical staff reminders being distributed.

For restrictive practices and the use of chemical restraint, I acknowledge the communications to staff about completing assessments (including consideration and use of best practice alternatives) prior to administration of ‘as needed’ medication and post-administration evaluation. I also note the engagement of appropriate specialists to monitor and review changed behaviours. There have been no other continuous improvement actions identified in relation to maintaining consistent practice for chemical restraint use including assessments, post-administration evaluations and identification and implementation of non-pharmacological interventions.

For mechanical restraint, I note that under section 15E(2) of the Quality of Care Principlesa mechanical restraint is defined as, ‘a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient’s movement for the primary purpose of influencing the care recipient’s behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient.’

A number of requirements are applied by the Quality of Care Principles for the use of a mechanical restraint as a restrictive practice, which includes (but is not limited to):

* the mechanical restraint must only be used as a last resort to prevent harm to consumers or other persons, and after consideration of the likely impact of the use of the restrictive practice to consumers
* to the extent possible, best practice alternative strategies have been used before the mechanical restraint is used and when used, the mechanical restraint is used only to the extent that is necessary and in proportion to the risk of harm to the consumer or other persons
* the mechanical restraint is used in the least restrictive form, and for the shortest time, necessary to prevent harm to consumers or other persons
* the use of the mechanical restraint must be in accordance with the consumer’s documented care and services plan and must include a behaviour support plan.

Based on the information provided, I find that mechanical restraint has not been used in accordance with the Quality of Care Principles. There is no evidence to support that comprehensive assessments for consumers subject to mechanical restraint were completed to ensure that restrictive practice were used in accordance with legislative responsibilities. Whilst I acknowledge that behaviour support plans have been recently updated, they have not included details about individualised triggers and underlying causes for changed behaviours or person-centred behaviour support strategies to support consumers subject to mechanical restraint.

The extended use of a restrictive practice does not reflect best practice. The Quality of Care Principles require that restrictive practices are only used in their least restrictive form and for the shortest time period necessary to prevent harm to consumers and others. The use of mechanical restraints for the extent necessary and in proportion to the risk of harm has not been demonstrated. Whilst the approved provider has indicated the application of a mechanical restraint for 24 hours every day was in the best interests of consumers, evidence of comprehensive assessment which supports the need for the mechanical restraint to be used for this period of time has not been provided.

The Charter states that all consumers have the right to be treated with dignity and respect and to be informed about their care and services in a way they understand. I find that the inappropriate use of mechanical restraint, including the use of this restrictive practice for a significant period of time and at all times without appropriate assessment or recognition that it is restrictive practice, does not recognise or demonstrate the consumer’s right to dignity and respect.

On the issue of consent, I do not accept that a consumer who does not resist the application of a restrictive practice is providing their ‘implied consent’ by allowing, for example, a mechanical restraint to be applied ‘without struggle’ and is consenting to its use by not facilitating its subsequent removal. And whilst I acknowledge the communication challenges that may arise in determining the needs and preferences of consumers, appropriate attempts to facilitate communication which helps consumers to understand their care and make informed decisions based on their individual needs has not been demonstrated.

For the reasons discussed above, I find that Requirement 3(3)(a) is Not Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Most consumers and consumer representatives expressed satisfaction with the quality and quantity of meals provided and confirmed special dietary needs and preferences were catered for. Positive interactions were observed during the dining experience between consumers and staff. Staff described that dietary assessments captured individual consumer dietary needs and preferences, which was consistent with care and planning documentation. Consumer engagement in menu planning was evidenced through food focus groups and consumer feedback about meals and their dining experiences. Management discussed extensive renovations which were being undertaken to meet consumer meal and dining expectations.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Consumers and consumer representatives provided positive feedback about care delivery and noted staff were well trained. Effective recruitment and selection processes were demonstrated. Staff described the orientation and onboarding processes which included mandatory training, competency assessments, role-specific training and buddy shifts. Whilst limited training records were available as the service transitions to a new online training system, staff had undertaken training in the Serious Incident Response Scheme, open disclosure, behaviour management, continence care, skin integrity and wound management. Management discussed improvements captured in the plan for continuous improvement which included training follow-up, and monitoring and analysis of staff training needs.

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)