Performance

Report

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| Name: | Juniper Annesley |
| Commission ID: | 7838 |
| Address: | 4-10 Hayman Road, BENTLEY, Western Australia, 6102 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 9 April 2024 to 10 April 2024 |
| Performance report date: | 16 May 2024 |
| Service included in this assessment: | Provider: 93 Uniting Church Homes  Service: 4851 Juniper Annesley |

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 Juniper Annesley (**the service**) has been prepared by R. Beaman, 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 30 April 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 Requirement (3)(b)**

* Ensure high impact or high prevalence risks associated with consumer care are effectively managed, including weight loss.

**Standard 7 Requirement (3)(c)**

* Ensure the workforce is competent and has the qualifications and knowledge to effectively perform their roles including in relation to medication and incident management.

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

* Ensure the organisation’s risk management system is effective, including in relation to incident management, the management of high impact or high prevalence risks, and supporting consumers to take risks to live the best life they can.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement (3)(b) is non-compliant.

**Requirement (3)(b)**

* The assessment team recommended Requirement (3)(b) not met as they were not satisfied the service effectively managed high impact or high prevalence risks associated with consumer care specifically in relation to weight loss and consumers at risk of choking. The assessment team included the following information and evidence gathered through observations, documentation, and interviews relevant to my finding:
* Three consumers with unplanned weight loss did not have the effectiveness of supplements monitored to manage further weight loss. One named consumer had a weight loss of 9.5kg between September 2023 and January 2024 and staff did not manage this in line with policy or procedures, the consumer’s oral intake was not monitored, assessments were not undertaken when the weight loss was identified, and they were not referred to the dietician for review in a timely manner to develop strategies to prevent further weight loss occurring.
* One named consumer who had a weight loss of almost 10kg between December 2023 and April 2024 and the service did not demonstrate any action had been taken in relation to this including not evaluating the effectiveness of nutritional supplements or referring to the dietician for further investigation. Interventions on the consumer’s weight chart following consecutive periods of weight loss included an action to encourage food and fluids for this consumer. A referral to the dietician for this consumer was actioned post feedback being provided by the assessment team.
* One named consumer had three consecutive months of weight loss recorded between January 2024 and March 2024 and staff did not action any review of the consumer’s nutritional care or follow policy and procedures and refer to the dietician for review.
* Two named consumers who are at risk of choking and aspiration, have a dignity of risk in place in relation to their choice to consumer food and fluids are not monitored as per the strategies documented to mitigate their identified risks. Staff confirmed neither consumer is supervised or monitored during meals as per their risk assessment.

The provider acknowledged the information in the assessment team’s report and provided actions they have taken and plan to take to address the deficits identified. The provider asserts for the three named consumers who experienced weight loss, each have been reviewed, and care documentation updated to include strategies to manage and mitigate further weight loss. For the consumer who did not have weight loss identified the provider included additional information to show the consumer is now weighed weekly and was referred to and reviewed by the dietician post the assessment contact visit. In relation to the two consumers who choose to take a risk and have food and fluids not in line with assessed recommendations, the provider included additional information to show discussions have now been undertaken with both consumers and their substitute decision makers with strategies in place to mitigate the risk including supervision for meals and set up for meal assistance by staff.

I acknowledge the additional information and commentary included in the provider’s response, however, I find the service did not demonstrate high impact or high prevalence risks to consumer care are effectively managed for each consumer. In coming to my finding, I have considered the information in the assessment team’s report that indicates for three consumers care in relation to weight loss was not optimal and was not monitored or managed effectively which impacted those consumers negatively. I have also considered for the two consumers with choking and aspiration risk, whilst they choose to take a risk to consumer food and fluid that is not in line with allied health recommendations, the risks to their health and wellbeing are not consistently monitored in line with care plan directions or recommendations from allied health team.

I acknowledge the actions the provider has taken immediately following the assessment contact and plans to implement to improve performance in this requirement, however these will need time to be fully embedded for efficacy and I encourage the provider to continue with those.

Based on the information above, I find Requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(g)**

Consumers and representatives confirmed staff practiced infection control and were confident the service had appropriate infection control measures in place. Staff confirmed they receive training in relation to infection control at regular intervals and have policies and procedures to support them where they need it. The assessment team observed staff practicing appropriate infection control throughout the visit including hand sanitisation and wearing masks. Documentation confirmed the organisations outbreak management plan is in place at the service and is regularly updated.

Based on information in the assessment team’s report, I find Requirement (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Consumers and/or representatives are satisfied with the cleanliness of the service environment and confirmed it is well maintained, safe and comfortable. Consumers were observed moving freely indoors and outdoors. Staff had knowledge of and described the service’s cleaning and maintenance policies, systems and processes and provided examples of how they manage reactive cleaning and report maintenance items. Documentation confirmed the service has a reactive and preventative maintenance system with a priority system to ensure issues reported are resolved in a timely manner.

Based on the information in the assessment team’s report, I find Requirement (3)(b) in Standard 5, Organisation’s service environment compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement (3)(a) is non-compliant.

At the assessment contact in April 2024 the assessment team were not satisfied the workforce was competent or have the qualifications or knowledge to effectively perform their roles specifically in relation to medication and incident management. The assessment team provided the following information and evidence gathered through observation, interview, and documentation relevant to my finding:

* Documentation confirmed multiple medication incidents had occurred at the service since December 2023 including staff not signing for medications after administration, medications being signed as administered but not administered, and for one consumer three incidents where medication was signed for but found still in its package.
* Incident forms are not completed accurately by staff to identify staff involved in medication errors, for competency to be assessed or reassessed or for investigations to be completed. Six medication incidents between December 2023 and April 2024014 were identified in the incident management system that had not been closed or investigations undertaken.
* Management confirmed staff are only assessed once for medication competency and if there are repeated or serious errors staff would be asked to repeat the medication competency.
* The service was unable to provide evidence that staff had been provided further education or counselled following medication incidents that were recorded in the incident management system.
* Clinical staff advised they can request further training if they need it.

The provider acknowledged the information in the assessment team’s report and included the actions planned and already implemented in response to the deficits identified. The provider has implemented a local monitoring process for medication incidents to capture staff involved in those, the leadership team are undertaking further education around incident management systems and the clinical manager is undergoing mentoring and coaching to provide onsite support.

I acknowledge the actions the provider has taken to address the deficits identified in the assessment team’s report, however I find the service did not demonstrate the workforce is competent or have the knowledge to effectively perform their roles specifically in relation to medication incidents and the incident management system. In coming to my finding, I have considered for medication incidents staff are making multiple errors in the administration of medication in that they are not signing once administered or signing and not administered, however the service is not able to identify staff who are making these errors and as a result unable to monitor or assess staff competency in relation to medication management effectively. I have also considered and placed weight on the information in the assessment team’s report that confirms staff competency for medication is done once and when there are repeated errors or serious incidents, however as the service is not always able to identify which staff are making the errors or involved in the incidents they cannot undertake an effective review of staff competency in relation to medication management.

I acknowledge the actions the provider has taken since the assessment contact visit and those still planned and find they will need more time to be fully embedded for efficacy.

Based on the reasons above, I find Requirement (3)(c) in Standard 7 Human resources 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. | Not Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement (3)(d) is non-compliant.

At the assessment contact in April 2024 the assessment team were not satisfied the service had an effective risk management system in place, specifically in relation to incidents, and consumers taking risks to live their best life. The assessment team provided the following information and evidence gathered through observation, interview, and documentation relevant to my finding:

* Staff are not following the organisation’s incident management policies and procedures and do not complete investigations of incidents in a timely manner to evaluate the effectiveness of current mitigation strategies or develop new ones.
* One named consumer with incidents of absconding, Serious Incident Response Scheme (SIRS)documentation for the incident occurring in October 2023 recorded half hour visual monitoring, installing keypads to the front and back doorways of the service, and a personal pendant alarm for the consumer to carry. However, none of the strategies were actioned and the consumer was involved in another incident where they left the service without staff knowledge placing the consumer at risk of harm as the service is located on a busy road.
* SIRS documentation recorded a consumer inappropriate touching another consumer, with actions to mitigate the incident from recurring documented as telling the consumer who made the allegation to not sit next to that consumer in future. No mitigation strategies to manage the behaviour and prevent recurrence were recorded.
* The incident management system is not effective in identifying recurring incidents specifically medication errors. Multiple errors have occurred, and the system has not identified incident forms are not accurately completed or investigations to determine possible causes have not taken place.
* Three named consumers with known risks in relation to choking and aspiration and have a dignity of risk in place, do not have their risks reviewed at regular intervals and interventions. Staff confirmed they do not supervise meals for these consumers when they have meals in their rooms.
* Consumers with restrictive practices in place including mechanical and chemical restraints do not have the risks associated with the restraint reviewed at regular intervals to minimise their risk of harm.

The provider acknowledged the information included in the assessment team’s report and provided actions that have been implemented and planned to address the deficits identified. The provider asserts they have ordered the pendant for the consumer who has had two incidents of absconding, and continues with the sighting chart, behaviour support plan for the named consumer with inappropriate contact has been reviewed and behaviour charting is in place to monitor the consumer with detailed interventions included to guide staff, further education for clinical staff in relation to the incident management system and a review of restrictive practices and named consumers care updated to reflect current care.

I acknowledge the actions the provider has taken and planned to implement, however I find the service’s risk management system has not been effective. In coming to my finding, I have considered for the consumer with incidents of absconding, the risk management system and processes were not effective in ensuring documented strategies to mitigate risks to the consumer of further incidents or potential harm were implemented and a further incident occurred. I have also considered the incident management system is not effective in identifying the medication errors that are occurring or ways to prevent recurrence as staff do not complete incident forms accurately and staff are not always able to be identified.

Whilst three named consumers have dignity of risk forms in place for risks associated with choking and aspiration, I have considered the organisation’s governance in relation to risk has not identified those risks are not regularly reviewed for effectiveness. Further to this staff confirmed the interventions that are currently in place, including supervision during meals are not always undertaken and the consumers are at risk of harm.

I acknowledge the actions the provider has taken since the assessment contact visit and those still planned and find they will need more time to be fully embedded for efficacy.

Based on the reasons 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)