Performance

Report

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| Name: | Juniper Hayloft |
| Commission ID: | 7468 |
| Address: | 1 Lewis Road, MARTIN, Western Australia, 6110 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 4 July 2024 |
| Performance report date: | 5 August 2024 |
| Service included in this assessment: | Provider: 93 Uniting Church Homes  Service: 19395 Juniper Hayloft |

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 Hayloft (**the service**) has been prepared by Genna Tonarelli, 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 26 July 2024, including a Plan for Continuous Improvement (PCI); and
* the performance report dated 5 October 2023 for the Assessment Contact- site conducted on 6 September 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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 each consumer gets safe, effective and tailored clinical care, including the effective management of high impact or high prevalence risks. This includes, but is not limited to:

* Ensure staff have the skills and knowledge to identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including pressure injuries and risks associated with bowel and bladder management.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks.
* Ensure continuous improvement items are implemented as per the PCI.

**Standard 8, requirement (3)(d)**

* Review the organisation’s risk management systems and practices in relation to how high-impact, high-prevalence risks are being managed and investigated to ensure deficits are promptly identified and actioned.
* Ensure staff have the skills and knowledge to understand their reporting obligations under the Serious Incident Response Scheme (SIRS)s to adequately identify and respond to incidents of abuse and neglect and unexpected death.
* Ensure policies and procedures are amended to include an investigation requirement following serious incidents and clinical events.
* Ensure continuous improvement items are implemented as per the PCI.

# 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 |

**Findings**

The Quality Standard is assessed as non-compliant as the one requirements assessed has been found non-compliant. The Assessment team recommended requirement (3)(b) not met.

Requirement (3)(b) was found non-compliant following an Assessment contact-site in September 2023. The provider failed to demonstrate timely and appropriate interventions to preserve skin integrity and prevent pressure injuries (PI). Several examples were provided where the interventions were ineffective. At this time, the provider acknowledged the deficits and agreed to implement actions as part of its continuous improvement process to resolve the identified deficiencies.

At the Assessment Contact in July 2024, the Assessment Team concluded that the improvement actions implemented by the provider were insufficient, as deficits in wound management persisted. The Assessment Team reported:

* Six consumers were identified with pressure injuries acquired at the service. Five consumers had pressure injuries on their heels, and one consumer on their ankle, following prolonged periods of redness. Despite staff delivering wound care in accordance with wound management plans and pressure injury prevention measures being in place, photographs and wound charts indicated prolonged skin redness before the stage 2 and suspected deep tissue (SDTI) Injuries were identified. Documents showed that while the identified PI had not worsened, they remained unresolved for as long as four months post identification.
* The recurring theme of heel-related pressure injuries and prolonged redness prior to the PIs being identified was acknowledged by the service. However, no evidence was provided to demonstrate investigations into these systemic issues.
* The clinical risks associated with a consumers' multiple complex care needs, including a stage 3 PI wound and bowel/bladder management, were not effectively managed. This led to acute deterioration in a consumer’s condition, resulting in their transfer to hospital where they passed away 3 days later. Post-mortem, the service failed to provide evidence of reviewing how it managed the risks related to bladder management and bowel impaction, despite the care records indicating ineffective management.

The provider acknowledged these findings and submitted an updated PCI to address the identified deficits. The PCI outlined:

* Steps to enhance complex wound management by reviewing systems to implement ongoing surveillance, measures, and post-wound tracking, and by increasing the knowledge of clinical staff through education and training in the Braden Risk Assessment scale, skin care, early pressure injury education, wound charting, bowel management, and early identification of deterioration and refusal of care.
* A review of policies and procedures related to initial and ongoing assessment, and referral and review processes for consumers returning from hospital and clinical incidents.

While the provider's response did not fully address systemic enhancements to respond to identified themes, it prioritised wound reviews, giving priority to consumers with existing PIs.

After reviewing the Assessment Team’s report and the provider’s response, I find the provider is not delivering effective and best practice clinical care that optimises consumers’ health and well-being, specifically in monitoring skin integrity and managing bowel and bladder issues.

Wound management, changes to skin integrity were not identified until PIs reach stage 2 or become SDTI, and the timeframes to resolve these injuries are prolonged, despite the presence of wound care practices and prevention strategies. Evidence indicates that consumers developing stage 2 and SDTI PIs experienced prolonged skin redness beforehand, which staff reported but did not effectively manage. While the service is managing some aspects of wound care, such as charting and identification strategies, the requirement mandates that providers manage all risks associated with the personal and clinical care of each consumer. I give weight to the adverse outcomes experienced by six consumers who did not have appropriate prevention strategies reviewed for effectiveness, leading to prolonged deterioration of their skin integrity.

Bowel impaction and bladder management, evidence suggests the service failed to review preventive strategies adequately, addressing the multiple complex care needs of the consumer, including a stage 3 PI and bowel and bladder management issues, and refusal of care. This consumer was identified in the Assessment Contact-Site in September 2023 report as having a Stage 2 PI in the same area. At that time the Assessment Team found that while complex strategies had been established and implemented, there were some gaps in review for effectiveness. Evidence from the July 2024 Assessment Team’s report indicates the consumer’s death in hospital, including the cause of death was not specifically known by the service and an investigation into the service’s risk management of the consumer while in their care, was not completed. Despite the provider suggesting it conducted appropriate inquiries following the consumer’s death in hospital, a no additional evidence was provided to refute these findings or demonstrate sufficient investigation occurred.

While the service has implemented system enhancements to address deficiencies in this requirement, these improvements are not yet effectively embedded into everyday practice, as noted in the provider's PCI. Despite efforts to rectify previous issues related to PI and wound care, these changes are not consistently applied to ensure high-impact risks associated with PI wounds and other complex risk are properly identified, investigated, and addressed.

Though planned improvements are recognised, there is concern that past implementations, particularly in wound management, have been ineffective. Risks continue to go unaddressed through the provider's monitoring mechanisms, and incident investigations do not appear to inform continuous improvement.

In relation to the PCI, it is crucial the service promptly embeds a system for staff to report changes to, monitor, review, and implement prevention strategies for consumers compromised skin integrity, bladder management, and bowel impaction.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(b) 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

The Quality Standard is assessed as non-compliant as one requirement assessed has been found non-compliant. The Assessment team recommended requirement (3)(d) not met.

The Assessment team found the service lacked an effective risk and incident management system to identify, minimise, and prevent high impact or high prevalence risks or incidents. The team reported:

* Deficits in managing PIs as noted in the Assessment Contact in September 2023, remain unresolved, impacting multiple consumers. Although the organisation collects incident data, it has not identified all contributing factors or developed appropriate strategies to minimise ongoing risks.
* The service does not consistently investigate or report serious incidents. It failed to review or make inquiries into the care of two consumers who recently died. One consumer (A) died following an unplanned hospital transfer due to a suspected infection, and the other (B) from injuries sustained following a severe incident and possible suicide. The organisation claimed to have conducted root cause analyses for Consumer B but provided no evidence to show this occurred.
* With no investigation the organisation cannot determine whether it has any reporting obligations under the Serious Incident Report Scheme (SIRS). In Consumer A’s case the organisation did not consider reporting the death and with Consumer B the organisation only reported 5 days post death, despite the consumer being found with severe injuries and subsequent hospitalisation.

The provider acknowledged these findings and submitted an updated PCI to address the identified deficits. The PCI outlined steps to improve risk and incident management systems by:

* Reviewing procedures and processes relating to consumers returning from hospital, SIRS notification and monthly data analysis to identify clinical incidents and themes.
* Delivering staff training and education into complex incidents training, incident management, SIRS and escalation procedures.
* Refining internal reporting and review mechanisms including an Internal Incident Management Category Taxonomy to include intentional self-harm and updating review forums to include incident and clinical analysis as standing agendas.

After reviewing the Assessment Team report and the provider’s response, I conclude the organisation lacks effective risk management systems and practices in identifying and responding to abuse and neglect and managing high impact risks associated with consumer care.

The findings reveal ineffective management of skin integrity issues and escalation. Evidence of prolonged ongoing redness prior to skin deterioration, indicate the risk based system were not effective in identifying this deficit. Additionally, several consumers presented high-impact PIs on their heels, which went unrecognised. Regarding incident management, the organisation did not provide evidence of completed incident forms or investigations outcomes for five consumers who experienced ongoing redness prior to wound deterioration.

I have also given weight to the deficits in clinical practice, in relation to abuse and neglect, by failing to adequately respond to consumers experiencing increased redness to their skin prior to developing PI and the clinical risks associated with Consumer A, who experienced medical conditions leading to deterioration. While I recognise the organisation has processes to identify and respond to abuse and neglect which includes SIRS reporting and investigation, I have considered for Consumer A that the service did not demonstrate effective mechanisms to identify the risks and prevent the decline, and therefore strategies to manage the potential neglect were not recognised. Additionally, the organisation failed to demonstrate investigation into the effectiveness of risk management pre/post the incidents involving, and/or death of, Consumers A and B, and failed to report the incidents/unexpected deaths to SIRS in a timely manner. There was no documentation provided to support a claimed investigation for Consumer A or root cause analysis for Consumer B.

Despite some understanding of this requirements, evidenced by established policies and procedures, the organisation is expected to have systems ensuring appropriate protections and safeguards, effective incident response, legal reporting, and awareness to reduce elder abuse risks. The evidence suggests these systems were ineffective to manage the risks associated with consumers A and B. Non-compliance with Standard 3 Requirement 3(3)(b) was also noted, including ineffective management of PIs, bladder risks, bowel impaction, and refusal of care. Ineffective clinical oversight and incident analysis further support this finding.

While the service has implemented system enhancements and reviews to address deficiencies in this requirement, these improvements are not yet effectively embedded into everyday practice, as indicated by in the provider's planned completion dates.

For continuous improvement, the organisation must promptly review its risk management systems, including skin integrity, bladder/bowel management, and care refusal, both pre and post-incident. The organisation should also review incident management and SIRS reporting systems to ensure compliance with internal policies and legislation.

Based on the evidence and reasons detailed, I find Requirement 8(3)(d) non-compliant.

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)