Performance

Report

**1800 951 822**

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| Name: | Kensington Park Nursing Home |
| Commission ID: | 7916 |
| Address: | 62 Gwenyfred Road, KENSINGTON, Western Australia, 6151 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 15 March 2024 |
| Performance report date: | 30 April 2024 |
| Service included in this assessment: | Provider: 934 Fresh Fields Aged Care Pty Ltd  Service: 4921 Kensington Park Nursing Home |

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 Kensington Park Nursing Home (**the service**) has been prepared by R Falco, 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, management, consumers, and representatives; and
* the provider’s response to the assessment team’s report received 24 April 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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.

**Standard 3 requirement (3)(b)**

* Review and monitor the management of high impact or high prevalence risks related to choking or aspiration.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence risks, specifically choking or aspiration.

# 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. | Non-compliant |

Findings

Effective management of high impact or high prevalent risks associated with consumers’ wounds, weight loss and falls was demonstrated. However, the assessment team recommended requirement (3)(b) not met as effective management of high impact or high prevalence risks relating to choking or aspiration was not demonstrated. Three consumers with specialist directives were not provided meals according to their dietary requirements and documented risk management strategies were not followed during meal service.

The provider did not agree with the recommendation made by the assessment team and felt some information in the assessment team’s report had understandably been missed or misinterpreted, thereby not supporting a finding of not met. The provider explained that although meals were served outside the dietary requirements for the 3 consumers, care staff cut food into smaller pieces for 2 of the consumers before assisting them to consume their meal. The provider described the service as having small communal living areas and stated staff are in close proximity to consumers at all times, particularly during mealtimes when all available staff are generally assisting consumers with their meals. Staff are constantly monitoring consumers during meal service, even if not providing one-to-one supervision.

I acknowledge the provider’s response, however, I find high impact or high prevalence risks for the identified consumers in relation to choking or aspiration was not effectively managed. Observations showed staff serving meals without checking dietary requirements despite staff stating they are required to check the dietary requirements card before serving meals. Two consumers were placed at risk even though the provider stated care staff cut food into pieces before assisting them with their meals. There is a risk the identified consumers could attempt to consume the meals before assistance is provided. The risk could potentially increase if staff are delayed in providing assistance due to unforeseen circumstances.

I acknowledge the provider’s concern that many consumers can be intimidated and distracted by direct supervision which can negatively impact their dietary intake and, as such, the provider stated all consumers are discretely observed by staff during meal service, even if not providing one-to-one supervision. However, consideration should be given to consumers who have an assessed need to be supervised at meal service to mitigate risks of choking or aspiration. For one of the identified consumers, management acknowledged the meal served was outside their dietary requirements, however, the consumer was permitted to continue finishing their meal without the appropriate supervision as documented in their care plan. I note the consumer’s representative consented to meals being provided outside their dietary requirements, however, this does not negate the need to consider documented risk mitigation strategies.

I have considered the service did not always ensure each consumer received the correct meal as required, nor did they follow the documented strategies to mitigate choking or aspiration risks. The provider’s speech pathologist agreed the diets provided for the 3 consumers, identified as being at high risk, were not appropriate to meet their assessed needs.

The service currently has an open Serious Incident Response Scheme incident relating to a consumer’s choking and subsequent death. An internal clinical review instigated actions to prevent the reoccurrence which included staff training and review of dietary requirement cards to ensure currency. I note the service has identified the need to coordinate meal service and a project is underway to appoint a champion to oversee the meal service. I consider time is required to monitor the effectiveness of this project.

Based on the assessment team’s report, I find requirement (3)(b) in Standard 3 Personal care and clinical care 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)