Performance

Report

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| Name: | Kerrisdale Gardens |
| Commission ID: | 5383 |
| Address: | 35 Norwood Parade, Beaconsfield, Queensland, 4740 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 16 July 2024 to 17 July 2024 |
| Performance report date: | 12 August 2024 |
| Service included in this assessment: | Provider: 3310 Good Shepherd Lodge Ltd  Service: 8008 Kerrisdale Gardens |

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 Kerrisdale Gardens (**the service**) has been prepared by S Turner, 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 2 August 2024
* other information and intelligence held by the Commission in relation to the service

# 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.

* The service is required to effectively manage high prevalence and high impact risks to consumers, including in relation to falls management and mental health.
* The service is required to identify and respond to changes or a deterioration in a consumer’s condition in a timely manner and to ensure clinical records support care delivery.
* The service is required to establish an effective risk management system that manages and prevents incidents, including high-impact and high-prevalence risks associated with the care of consumers.

# 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)(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. | Not Compliant |

Findings

Having considered the Assessment contact-site report for the Assessment contact conducted 16 July 2024 to 17 July 2024 and the approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied Requirements 3(3)(b) and 3(3)(d) are non-compliant. Non-compliance is based on the following analysis:

Requirement 3(3)(b)

The service did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of consumers. Care documentation did not consistently include details or strategies for the management or monitoring of high-impact or high-prevalence risks associated with the care of consumers and staff did not demonstrate a shared understanding of strategies to manage the risks. For example:

* Care planning documentation for a consumer who had experienced a number of falls and who was identified as being a high falls risk, included limited care directives relating to manual handling and mobility; strategies that were documented were inconsistent and were not reflective of the consumer’s current care needs, as reported by staff. Staff did not have a shared understanding of strategies to be utilised to minimise the risk of falls and care delivery was not consistently delivered in accordance with care planning documentation.
* For a consumer with a mental health history who was identified through the use of a depression screening tool as having depressive symptoms and who had previously demonstrated high-risk behaviours, care documentation failed to include strategies to guide staff in supporting the consumer’s mental health. Strategies outlined in care documentation to support the consumer’s safety, such as regular monitoring of the consumer, were not recorded as being completed. Additionally, observations were made of chemicals including cleaning fluids that were unattended and accessible to consumers.

The Assessment contact-site report includes information under Requirement 3(3)(b) relating to the management of a consumer who became unresponsive during the delivery of hygiene cares; I have considered the weight of this information under Requirement 3(3)(d).

The approved provider’s response acknowledged the deficits identified in the Assessment contact-site report and provided additional clarifying information. Improvement initiatives included:

* Processes for assessing and managing high-impact risks are to be reviewed against best practice methodologies to ensure currency.
* Identification of those consumers who have high-impact risks associated with their care and review of the care plans to ensure current strategies are effective and are appropriately implemented and documented.
* Staff to be trained in the identification and management of high impact risks.
* Staff compliance with the established processes to be monitored.
* The risk register is to be reviewed and updated.

The improvement initiatives include a focus on:

* + falls management protocols
  + the identification, management and support of consumers who experience a change in mental health, and
  + the management of consumers at risk of deterioration.

Based on the Assessment contact-site report and the approved provider’s response I am satisfied that:

* The service’s processes to manage high impact and high prevalence risks to consumers were not consistently effective.
* Risks to consumers identified in the Assessment contact-site report were not being effectively identified and managed and care documentation was not sufficiently detailed to inform care delivery and guide staff.
* The approved provider’s response identified actions to address deficiencies in the above areas and included a plan for continuous improvement, a consumer specific action plan and the staff training and education plan. However, actions are yet to be fully implemented or are in their infancy and will take some time to embed in practice and be tested for effectiveness and sustainability. Further, evidence of improved outcomes for consumers was not included in the approved provider’s response.

For these reasons, I have decided Requirement 3(3)(b) is non-compliant.

Requirement 3(3)(d)

The service did not demonstrate that a deterioration or change in a consumer’s condition was consistently recognised and responded to in a timely manner. For example, the Assessment contact-site report includes information:

* For one consumer who had experienced a change in their cognitive status and who had a history of falls including a fall where the consumer sustained a fracture, care related documentation failed to reflect the consumer’s cognitive status in the falls risk assessment process. While the consumer’s progress notes documented multiple instances of confusion, strategies included in care planning documentation to minimise falls were not reflective of the consumer’s cognitive status and included strategies, such as the use of a pendant alarm, that were not understood by the consumer. While staff provided feedback during the Assessment contact that the consumer had the capacity to use a pendant alarm, I am not persuaded that for this consumer, this was an effective falls prevention strategy as progress notes included a number of entries where the consumer was confused about the purpose of the pendant. Incident data for a recent fall included recommendations for the implementation of a chair sensor; at the time of the Assessment contact this had not been implemented. However, management advised a chair sensor would be ordered for the consumer on the second day of the Assessment contact.
* For a second consumer who reported a change in balance and a history of falls, the Assessment contact-site report includes information that a falls risk assessment was not completed following two falls, one of which involved hospitalisation. Following a third fall, a falls risk assessment was completed and included recommendations to ensure the call bell was in reach, a pendant alarm was available, and a chair and bed sensor was in place. The Assessment Team observed the consumer sitting in a chair during the Assessment contact and to have a call bell in reach however the consumer was not wearing a pendant alarm and a chair sensor was not in place. The consumer advised they had dropped the pendant alarm a few days previously and the Assessment Team observed the lanyard strap was broken on the pendant alarm and advised staff. Staff were not aware the consumer had not been wearing the pendant alarm for a number of days. In response to this feedback management advised a chair and bed sensor would be ordered and installed for the consumer.
* One consumer experienced an episode of being pale and unresponsive during care delivery. While staff completed vital signs (temperature, pulse and respirations) this did not include the completion or documentation of neurological observations to assess the consumer’s neurological status. Care documentation did not include details such as the period of time the consumer remained unresponsive, nor did it provide details as to actions taken in response to blood pressure recordings that fell outside of range in the days following the incident.

The approved provider’s response acknowledged the deficits identified in the Assessment contact-site report and provided additional clarifying information including that for the second consumer, a chair sensor was in place. Improvement initiatives included:

* Staff to be trained in recognising and responding to deterioration including for consumers with impaired cognition.
* Assessment and care planning processes to be reviewed and staff performance and compliance with processes to be monitored.

Based on the Assessment contact-site report and the approved provider’s response I am satisfied that:

* The services processes to identify and respond to a change or deterioration in a consumer’s condition were not consistently effective.
* There were instances where care documentation did not reflect significant information and or details relating to a change in a consumer’s condition. Where changes were identified there was limited evidence demonstrating changes were acted upon.
* The approved provider’s response identified actions to address deficiencies in the above areas, however, actions are yet to be fully implemented or are in their infancy and will take some time to embed in practice and be tested for effectiveness and sustainability. Further, evidence of improved outcomes for consumers was not included in the approved provider’s response.

For these reasons, I have decided Requirement 3(3)(d) is 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

Having considered the Assessment contact-site report for the Assessment contact conducted 16 July 2024 to 17 July 2024 and the approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 8(3)(d) is non-compliant. Non-compliance is based on the following analysis and includes information brought forward by the Assessment Team under this requirement and Requirements 3(3)(b) and 3(3)(d):

The service did not demonstrate that an effective risk management system was established. For example:

* Strategies to minimise risk of harm for consumers who had a high risk of falls and for consumers who experienced changed cognitive function or changed mental health were not consistently reflected in care planning documentation and did not consistently reflect a consideration of the consumer’s current care needs including their cognitive status.
* Staff did not demonstrate a shared understanding of practices to support individual consumers or how to manage high-impact, high-prevalence risks to consumers. For example, staff were not able to identify strategies they would use to support a consumer with changed mental health.
* The service had developed a suicide management flowchart that included strategies to guide staff in supporting consumers; at the time of the Assessment contact, the strategies had not been implemented for a consumer where a need had been identified.
* Incidents were not consistently captured in the service’s incident reporting register and there were instances where the organisation’s policy of undertaking a root cause analysis following a significant incident, had not been completed. For incidents brought forward in the Assessment contact-site report there was limited evidence the incidents had been analysed and had informed continuous improvement.
* The Assessment Team observed unattended chemicals were accessible to consumers and this had not been identified as a risk to consumers including those with changed cognitive function and those with changed mental health.

The approved provider’s response acknowledged the deficits identified in the Assessment contact-site report and provided additional clarifying information. Improvement initiatives included:

* Processes relating to the incident management system are to be reviewed against best practice methodologies and include processes relating to trend analysis and root cause analysis.
* Internal reporting processes to be reviewed.
* Identification of those consumers who have high-impact risks associated with their care and review of the care plans to ensure current strategies are effective and are appropriately implemented and documented.
* Staff to be trained in the identification and management of high impact risks and risk management systems and practices.
* Staff compliance with the established processes to be monitored.
* Daily meeting for department heads and key clinical leaders to support the identification of day-to-day operational issues and key risks.

Based on the Assessment contact-site report and the approved provider’s response I am satisfied that the incident management system was not consistently effective in managing and preventing incidents including high-impact and high-prevalence risks associated with the care of consumers.

The approved provider’s response identified actions to address deficiencies in the above areas and included a plan for continuous improvement, a consumer specific action plan and the staff training and education plan. However, actions are yet to be fully implemented or are in their infancy and will take some time to embed in practice and be tested for effectiveness and sustainability. Further, evidence of improved outcomes for consumers was not included in the approved provider’s response.

For these reasons, I have decided Requirement 8(3)(d) is 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)