Performance

Report

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| Name of service: | Linsell Lodge Aged Care Facility |
| Service address: | 2-16 Cardigan Street ANGLE PARK SA 5010 |
| Commission ID: | 6084 |
| Approved provider: | The Salvation Army (South Australia) Property Trust |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 June 2023 |
| Performance report date: | 4 August 2023 |

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 Linsell Lodge Aged Care Facility (**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 - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Assessment Team’s report received on 10 July 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **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 2 requirement (3)(a)**

Ensure assessments and planning is undertaken with the consideration of risk to consumers’ health and well-being.

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

Ensure the high impact or high prevalence risks associated with care are effectively managed for each consumer.

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

Ensure the organisation’s risk management systems and practices are effective, specifically in relation to management of high impact or high prevalence risks associated with consumer care and an incident management system that prevents recurrence.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |

Findings

The Assessment Team were satisfied the service demonstrated care and services are culturally safe. Consumers sampled confirmed staff knew their needs and preferences in relation to the delivery of care and indicated they were delivered culturally safe care, including having personal care delivered by gender specific staff where they preferred to.

Staff demonstrated knowledge of consumers’ cultural backgrounds and the way they deliver care that is in line with cultural preferences and is culturally safe. Staff were able to describe consumers who wished to have care delivered by gender specific staff.

Sampled care planning documentation confirmed care and services are documented to guide staff practice to deliver care that is in line with consumers’ cultural preferences and safety.

Accordingly, I find requirement (3)(b) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |

Findings

The Assessment Team’s report recommended requirement (3)(a) not met as they were not satisfied assessment and planning effectively considered risks to consumer health and well-being, specifically in relation to the risk of falls for one consumer (Consumer A), behaviour management and use of psychotropic medications for another consumer (Consumer B) and consistent information being documented around wound care management. The Assessment Team’s report includes the following information and evidence gathered through observation, interview and documentation relevant to my finding:

* Wound assessments completed for three consumers were in line with directives, however, did not always include measurements, photographs did not include a ruler to show size of wound and not always on a consistent angle resulting in unclear images on some occasions.

Consumer A

* Consumer A was observed leaving the service independently using a wheelchair for mobility. Staff confirmed Consumer A leaves independently frequently.
* Consumer A’s care planning documentation included a Falls Risk Assessment (FRAT) undertaken on 17 April 2023 that showed a high risk of falls, falls prevention strategies, physiotherapy assessment and mobility and movement plan.
* Falls prevention strategies are documented, including for Consumer A to use their mobility aids and wait for staff to assist or supervise, and mobility assessment documents Consumer A can have dizziness with an assessment of steadiness required before they begin walking.
* A Consumer Risk Safety Assessment was completed in April 2023 and updated to include they will take themself to external appointments. The assessment did not identify any strategies to mitigate risk of falls or safety to Consumer A when outside of the service alone or demonstrate consideration of the assessed need for supervision and/or support from a staff member due to risk of unsteadiness, fatigue, pain or dizziness.

Consumer B

* Serious Incident Response Scheme (SIRS) reports identified Consumer B as having changed behaviours of physical aggression and inappropriate behaviours.
* Documentation also indicated attempts to abscond from the memory support unit and comments made by Consumer B of self-harm.
* Staff described strategies to manage Consumer B’s behaviour included 30-minute visual sighting checks, behaviour charting, commencement of medication to reduce their inappropriate sexual conduct and following incidents to take Consumer B for a walk or keep them separate from other consumers.
* Staff were unable to describe individualised behaviour management strategies for Consumer B.
* A chemical restraint authorisation form signed by the medical officer and substitute decision maker for psychotropic medication to manage anxiety and agitation dated May 2023 showed the medication was not considered a chemical restraint and medication to reduce sexual drive.
* On two occasions in June 2023, Consumer B was administered medication to manage agitation as a chemical restraint.
* Medication changes were made in June 2023 and Consumer B was prescribed anti-psychotic medication to manage increasing behaviours with no evidence of informed consent.
* Consumer B’s behaviour assessment does not include physical aggression and states this has occurred only once since admission. Behaviour charting and staff feedback indicate physical aggression from Consumer B has occurred on several occasions.
* Behaviour management strategies within the BSP were not personalised and did not record effectiveness of strategies or develop new strategies for trial.
* A Cognitive and Mental Health assessment has been reviewed seven times since Consumer B’s admission and only one change to strategies to manage behaviours has been made which increased visual sighting from one hour to 30-minute checks.
* Consumer B has not been referred to external dementia specialist services for review to identify strategies for managing changed behaviours.

The provider acknowledges the Assessment Team’s recommendations. The provider’s response includes a plan for continuous improvement with actions to address the deficits, including, but not limited to:

* Training to be provided to staff in relation to escalation policies and responsibilities in their role for behaviour charting.
* Undertaking an audit of behaviour charting to identify any training needs.
* Training to be provided to clinical staff around wound measurements to ensure they are entered in wound charts.
* Undertaking an audit of wound charts to identify any training requirements.

The provider’s response includes information and commentary in relation to the deficits identified. However, I find assessment and planning is not consistently undertaken with the consideration of risks to consumers’ health and well-being to inform the delivery of safe and quality care. In coming to my finding, I have considered the additional commentary included in the provider’s response that asserts the service has undertaken an investigation of issues identified for Consumers A and B and reviewed care and services for both consumers in relation to the deficits identified. In relation to Consumer A, the provider has included a Customer Risk Safety Assessment with strategies for staff and Consumer A to mitigate risks of falls when mobilising independently outside of the service, and a FRAT that shows Consumer A’s risk of falls has been reviewed on 30 June 2023 and is now a medium risk of falls not high risk of falls as indicated in the FRAT completed on 17 April 2023. A lifestyle assessment for Consumer A has been included that reflects their preference to leave the service independently with strategies around keeping safe recorded. I acknowledge the consumer has recently moved to the service and staff are getting to know them, however, a risk assessment had not been completed for Consumer A who was known to leave the service independently with impaired mobility and balance and a mild cognitive impairment. At the time of entry to the service, Consumer A was also a high falls risk. I also note the provider has implemented actions to address those deficits following the Assessment Contact visit.

In relation to Consumer B, the provider asserts they have undertaken a review of the behaviour management plan with updates to the interventions in the BSP and states a review by the geriatrician was undertaken on 6 July 2023 with recommendations made. The provider has included additional information, including a progress note of the geriatrician review that includes information about psychotropic medication changes, including antipsychotic medication for management of behaviours, and the BSP updated on 10 July 2023 that shows personalised interventions have been included. In coming to my finding, I have considered Consumer B did not have an effective behaviour management plan in place to guide staff practice in managing changed behaviours despite information available through behaviour charting showing frequent incidents and the administration of as required medication to manage incidents of agitation. I acknowledge the provider has implemented these actions following the Assessment Contact visit and encourage them to continue to implement these actions.

In relation to wound management, I acknowledge the information in the Assessment Team’s report and find the actions the provider has implemented to address those deficits will ensure wound measurements and photographs are appropriately completed and included in consumer wound management plans to guide staff to deliver appropriate wound care.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

# 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 |
| 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. | Compliant |

Findings

The Assessment Team’s report recommended requirement (3)(b) not met as the service did not demonstrate they effectively manage high impact or high prevalence risks associated with consumer care in relation to behaviour management for one consumer (Consumer B). The Assessment Team were satisfied the service recognises and responds to deterioration or change in consumer’s condition in a timely manner and recommended requirement (3)(d) met.

**Requirement (3)(b)**

The Assessment Team’s report includes the following information and evidence relevant to my finding:

* Consumer B did not have effective strategies to manage their changed behaviours identified through the assessment process. Consumer B’s behaviours include sexual advances towards other consumers and physical aggression towards staff.
* Strategies to manage Consumer B’s behaviours were not personalised and although care planning was reviewed behaviour incidents did not trigger the development of new strategies.
* Staff described Consumer B’s behaviours as inappropriate sexual conduct and physical aggression towards other consumers, however, stated behaviours were managed through behaviour charting, visual sighting and talking for a walk, and a clinical staff advised commencement of medication as a strategy for inappropriate sexual advances.
* Behaviour charting showed 38 of 37 entries over a four-week period (18 May 2023 to 15 June 2023) were physical aggression, inappropriate sexual contact and attempting to abscond, and three of the 38 entries were of Consumer B threatening suicide or self-harm.
* Of the 38 entries, only one included an evaluation of the effectiveness of strategies used and triggers were recorded as either behaviour, unknown or left blank.
* The visual sighting chart used as a strategy to manage Consumer B’s behaviours was not always completed in line with directives. Staff confirmed they were aware of the need to always monitor Consumer B’s whereabouts as they were considered a risk to themselves and other consumers.
* Progress notes did not include evaluation of behaviour charting and included other behaviour incidents that were not captured or recorded on the behaviour chart.
* Chemical restraint used on three occasions over a week (31 May 2023 to 9 June 2023) was not administered as a last resort. Psychotropic medication was administered on each occasion in response to changed behaviours, including anxiety, agitation and aggression.
* Management stated Consumer B’s behaviours were more significant than they were aware of on admission and were awaiting a review to occur with the geriatrician.

The provider acknowledges the Assessment Team’s recommendations. The provider’s response includes a plan for continuous improvement with actions to address the deficits including but not limited to:

* Training for staff in relation to documentation completion, including for restrictive practices.
* Audit of behaviour charting to identify training needs for staff.
* Training to be provided to staff in relation to the service’s escalation policy and their roles and responsibilities with that for behaviour management.
* The provider’s response also includes information and commentary in relation to the deficits identified. However, I find high impact or high prevalence risks are not effectively managed, specifically in relation to behaviours. I have considered the information included in the provider’s response that states they undertaken an investigation of Consumer B’s assessment and planning, reviewed their behaviour management plan and included personalised strategies to manage their behaviour. I have also considered the information included by the provider that shows the organisation’s policies for escalation of behaviours and restrictive practices which includes the escalation processes where risks are identified, including behaviours and for restrictive practices that non-pharmacological interventions are to be used before any medication administration.

In coming to my finding, I have placed weight on the information included in the Assessment Team’s report that shows Consumer B’s behaviours were not managed effectively, they had multiple entries on behaviour charting that showed escalating behaviours, including physical aggression, inappropriate sexual contact and proclamations of self-harm, that the strategies used by staff in those instances were in all but one occasion not evaluated for effectiveness to drive the development of new strategies to manage those behaviours and keep both Consumer B and other consumers at the service safe. While I note the provider’s response includes training undertaken with staff around escalation incidents and a review of Consumer B’s care plan to include personalised behaviour management strategies, those actions will need time to be fully embedded and evaluated to ensure ongoing effectiveness.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)**

Consumers and/or their representatives confirmed they were satisfied with the way staff managed any changes in consumer condition and felt they were responded to in a timely manner. Care staff demonstrated in-depth understanding of consumers and stated when they identify any changes in a consumer’s condition they escalate and report to their registered staff member on duty.

Sampled care documentation reflected consumers are monitored by staff and appropriate and timely escalation when a change in condition or deterioration is identified.

For the reasons detailed above, I find requirement (3)(d) in Standard 3 Personal care and clinical care compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The Assessment Team’s report recommended requirement (3)(c) not met as they were not satisfied appropriate action was taken in response to complaints made by consumers. However, I have come to a different view to that of the Assessment Team and my reasons are included below.

The Assessment Team provided the following information and evidence relevant to their recommendation:

* The service’s feedback log was unavailable at the time of the Assessment Contact visit due to management leave and of the two complaints provided consumer satisfaction was not recorded for one.
* One consumer indicated they were not satisfied with how their complaint was managed, advised they had not received a response and the complaint had not been resolved yet.
* Staff were not familiar with the term open disclosure but confirmed they are open and transparent with consumers and representatives when things go wrong or incidents occur.
* One representative advised they are kept informed of any incidents with their consumer and staff are open and transparent when things go wrong.

The provider acknowledges the Assessment Team’s report, however, disagreed with the findings. The provider acknowledges due to leave the paper-based complaints folder was not shared with the Assessment Team and included the following additional information in their response:

* Three completed feedback forms, including for the consumer sampled in the Assessment Team report, showing actions taken and outcomes with consumer satisfaction noted and a resolution to the initial complaint achieved.
* The service’s feedback report showing for May 2023 all compliments, suggestions and complaints lodged.

I acknowledge the information in the Assessment Team’s report, however, in coming to my finding, I have placed weight on the additional information included in the provider’s response that shows the process taken to action complaints. While for one consumer they may not have been initially satisfied with the management of their complaint, the provider has shown resolution of this with consumer satisfaction recorded. I acknowledge that during the Assessment Contact, the full feedback register was not available and have considered the assertion made in the provider’s response that they have provided additional training to management around accessing the report when the manager who holds the feedback portfolio is on leave. I have not been persuaded that this isolated incident shows a systemic gap in the service’s feedback and complaints system and also placed weight on the information in the Assessment Team’s report that shows staff understand and receive training around open disclosure of which a representative confirmed occurs.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints 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. | Non-compliant |

Findings

The Assessment Team’s report recommended requirement (3)(d) not met as they were not satisfied the organisation has an effective risk management framework, specifically in relation to management of high impact or high prevalence risks associated with consumer care or an effective incident management system.

The Assessment Team’s report provided the following information and evidence relevant to my finding:

* A report of all incidents occurring in the six months prior to the Assessment Contact visit was requested on three occasions throughout the visit and was unable to be accessed or provided to the Assessment Team.
* Clinical indicator data from January 2023 to June 2023 did not provide consumer information for any trending to identify patterns of time, day or consumer to identify strategies to mitigate the incidents.
* Information provided on SIRS reporting was not completed and did not include all SIRS incidents to enable effective trending of incidents.
* Management acknowledged the information contained in the SIRS folder was not up to date or organised to enable trending.
* The service could not demonstrate oversight of high impact or high prevalence risks, including multiple behaviour incidents for Consumer B.
* Clinical staff did not monitor or review behaviour charting as per the service’s processes to identify trends in behaviour incidents or regular occurrence for Consumer B.
* Behaviour charting for Consumer B identifies escalating behaviours but did not record the effectiveness of strategies used to enable new strategies to be developed.
* Weekly multi-disciplinary meeting minutes did not show effectiveness of behaviour strategies were discussed.

The provider acknowledges the Assessment Team’s report, however, disagreed with the findings and asserts the service has an effective risk management system. The provider included the following additional information in their response:

* Incident report graph from February 2023 to July 2023 showing an overview of incidents occurred by number, type and location.
* Training has been provided to staff on how to access the report in the absence of the service’s manager.
* Implementation of an automated SIRS register which is updated each time a SIRS report is submitted, including a copy of the register.
* Hard copy SIRS folder has been updated.
* Copies of two multi-disciplinary meeting minutes for May 2023 both include Consumer A and one includes Consumer B.

I acknowledge the information included in the provider’s response; however, I find the risk management system in place has not been effective in monitoring and managing high impact or high prevalence risks associated with consumer care, specifically in relation to behaviours and the incident management system was not effective in preventing the recurrence of incidents. In coming to my finding, I have considered the information and evidence included in the Assessment Team’s report that shows for Consumer B, multiple behaviour incidents, including physical aggression, reports of self-harm and inappropriate sexual conduct towards other consumers occurred with entries made in behaviour charting that was not monitored or reviewed effectively. I have considered that for behaviour incidents, the service’s risk management system did not identify clinical staff were not effectively monitoring or evaluating strategies used for effectiveness and, as such incidents continued placing both Consumer A and all other consumers residing in the same wing at risk of harm. I have also considered information included in requirement (3)(a) in Standard 2 that shows the service’s risk systems and processes did not identify there was no risk assessment or consideration of risk in place for activities undertaken by Consumer A. Furthermore, as these were not identified there were no mitigation strategies in place to ensure Consumer A’s safety and mitigate their risk of harm.

I acknowledge the information the provider’s response includes discussion of consumer risks, including the multi-disciplinary meeting minutes for two meetings in May 2023, however, I am not persuaded these have contributed to the effective management of risks. For Consumer A, meeting minutes dated 19 and 26 May 2023 note they frequently leave the service, however, this did not trigger a review of strategies when they are a known falls risk, with mobility and cognitive impairment, nor did it trigger a risk assessment to be completed. For Consumer B, meeting minutes show they were discussed at the meeting held on 26 May 2023, however, whilst behaviours are documented in the meeting minutes of suicidal expression and threatening, sexual behaviour and being very focused on women and trying to leave these did not trigger a review of the behaviour management strategies or referral to an external dementia specialist. I acknowledge the actions the provider has put in place since the Assessment Contact visit for both Consumers A and B and improvement actions to the risk management system and find they need more time to embed those actions to lead to sustainable improvements and I encourage the provider to continue to embed these improvements.

For the reasons detailed 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)