Performance

Report

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| Name: | Linsell Lodge Aged Care Facility |
| Commission ID: | 6084 |
| Address: | 2-16 Cardigan Street, ANGLE PARK, South Australia, 5010 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 29 February 2024 to 1 March 2024 |
| Performance report date: | 19 April 2024 |
| Service included in this assessment: | Provider: 53 The Salvation Army (South Australia) Property Trust  Service: 4101 Linsell Lodge Aged Care Facility |

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 A Kasyan, 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 27 March 2024 including plan for continuous improvement; and
* the performance report for the assessment contact undertaken on 9 November 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **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 2 Requirement (3)(a):**

* Ensure staff conduct comprehensive and accurate assessments.
* Ensure risk assessment tools are completed accurately and identify all risk factors and risk mitigating strategies.

**Standard 3 Requirement (3)(b):**

* Ensure all risk associated with the care of consumers are timely identified, mitigated and managed.

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

* Ensure effective risk management systems and practices.
* Ensure effective trending and analysis of clinical incidents and quality indicators.
* Ensure staff are aware of high impact high prevalence risks across the service.

# 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. | Not Compliant |

Findings

This Quality Standard is assessed as non-compliant as one requirement has been assessed as non-compliant.This requirement was found non-compliant following an assessment contact on 9 November 2023 where it was found whilst the service had a structured assessment and planning process, including consideration of risks, staff did not effectively use assessment and planning process to identify and plan management of risks, specifically of pressure injuries. Deficiencies in assessment and planning processes have led to ineffective delivery of care.

The assessment team’s report provided evidence of actions taken by the service to address deficiencies identified, including displaying information about care planning process around the service and updating consumers’ care plans.

At the assessment contact undertaken from 29 February 2024 to 1 March 2024 the assessment team found implementation of the improvements have not remedied deficits in assessment and planning process to inform the delivery of safe and effective care and recommended requirement 2(3)(a) not met.

The assessment team sampled files of consumers with a range of risks, including multiple falls, compromised skin integrity and risks associated with choices consumers make to live the best live. For three of the sampled consumers, documentation review showed staff did not conduct comprehensive and accurate assessments, did not consider all risks to consumer’s health and well-being and did not include risk mitigation strategies to inform safe delivery of care and services.

Whilst there was no evidence of harm for two consumers, one consumer with complex care needs has sustained multiple falls and developed incontinence associated dermatitis that has not resolved for over 4 months.

The provider responded by stating the service has been working on an action plan to address findings from previous assessment contact visits, focusing on improving care delivery in areas such as wound management, restrictive practices, behaviour support plans, clinical assessments and planning.

As of January 2024, the service has a new management team, and from January 2024 onwards, the manager overseeing operational support and quality advisors have been providing mentoring and essential support to the newly employed management team.

The provider acknowledges there were documentation gaps in the assessment and planning of the named consumers’ care and provided detailed action plan and additional information related to the three consumers’ care including but not limited to wound management plans, dignity of risk forms, consumer risk safety and smoking risk assessment, abstracts from progress notes and fluid intake charts.

The provider asserts assessments have been reviewed and completed since the assessment contact visit and the response included evidence to support this claim. The provider argues that whilst there have been deficiencies in assessing and planning and completing risks assessments, two named consumers were not negatively impacted by it. The third sampled consumer has had their care reviewed in consultation with them and their representative who expressed high level of satisfaction with care.

The provider does not agree with the recommendation of the assessment team as they state they feel confident with the current processes regarding assessments and planning to manage consumer risks. The provider states the service maintains an assessment tracker dashboard which obtains data from a clinical documentation system daily to ensure the care team is alerted when care plan reviews and care assessments are due. As of 25 March 2024, the compliance status on the assessment tracker indicates a 96.5% compliance rate.

Based on the assessment team’s report and the provider’s response, I find the service is non-compliant with requirement (3)(a). I acknowledge the provider’s response and supporting documentation demonstrating actions that have been taken since the assessment contact.

Whilst the provider states compliance status on the assessment tracker indicates a 96.5% compliance rate, assessments not only need to be completed in a timely manner, but they also need to be thorough, accurate and reflective of each consumer needs and lead to positive outcome for consumers.

I have also considered evidence and the provider’s response to the assessment team’s finding in Standard 3 requirement (3)(b) which are relevant to assessment and planning process. The provider stated multiple wound charts were created by staff for one wound due to their confusion in relation to the wound classification, specifically difficulty with differentiating pressure injury and incontinence associated dermatitis. Furthermore, the provider states one of the wounds that was an ulcer was incorrectly classified as a pressure injury.

Effective assessment of skin integrity issues involves accurate identification and documenting the nature of skin issues which informs the development of individualised care plans. The provider’s own monitoring mechanisms did not identify this deficit in staff knowledge prior to this assessment contact. Effective of staff training and other improvement activities on plan for continuous improvement will require time to evaluate and establish efficacy.

Based on the reasons summaries above, I find requirement (3)(a) 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. | Not Compliant |

Findings

This Quality Standard is assessed as non-compliant as one requirement has been assessed as non-compliant.

This requirement was found non-compliant following an assessment contact on 9 November 2023 where it was found effective management of high impact or high prevalence risks was not demonstrated for consumers with pressure injuries and wounds. Staff did not ensure correct implementation of pressure relieving strategies and timely administration of antimicrobial treatment which resulted in increased pain and compromised wound healing.

The assessment team’s report provided evidence of actions taken by the service to address the non-compliance. A quality advisor completed wound audits in February 2024, and staff referred consumers requiring review to wound specialist and dietitian. Registered nurse reviewed all chronic wounds and management conducts weekly reviews of the wounds. The service commenced weekly multidisciplinary meetings to discuss individual consumers’ high impact/high prevalence risks. Risk register is now available at the nursing station for all staff awareness.

Following the assessment contact undertaken from 29 February 2024 to 1 March 2024 the assessment team recommended requirement (3)(b) is not met.

Documentation showed two consumers were receiving time sensitive medications over 30 minutes late from the prescribed time and three consumers provided feedback indicating their dissatisfaction with timeliness of their medication administration. Staff confirmed medication rounds sometimes delayed and it is often due to unavailability of staff to administer medications.

The assessment team found risk of falls are not managed effectively due to one consumer’s fall when they rolled out of bed not being followed up in line with the policies and procedures. Documentation did not evidence pain assessment following this fall.

Risks associated with skin integrity were not managed effectively for one consumer because wound charts showed staff did not consistently provide a description of the wound, a photograph and measurements. Fluid intake charts were not completed consistently for a consumer who was on fluid restriction.

The provider responded to the assessment team’s report by stating the service continues to strengthen processes around high-impact or high-prevalence risks, as evidenced by the improvements in various risk areas. In the last reporting period, the service reported 0% of consumers with pressure injuries, a significant reduction in incidents of consecutive and significant weight loss. No consumers sustained an injury following a fall. Incident rate of incontinence associated dermatitis is low and sits at 1.12%.

The provider acknowledges delayed administration of time critical medication for named consumers and reported them to the Commission under Serious Incidents Response Scheme. The service has further investigated this in partnership with the local visiting general practitioner, who has ordered a new schedule for these time critical medications, providing a larger administration window time for these consumers in line with the consumers’ needs.

The provider acknowledge delay with administration of a medication to a consumer named in the report on the day of the assessment contact visit and apologised to the consumer. In relation to another consumer who provided feedback about the delay with receiving their nighttime medication, the provider included evidence showing these medications are administered as prescribed. The service has sent a request to a general practitioner to review the consumer’s medications due to their request to adjust the timing of the nighttime medications.

Prior to the assessment contact, the service was in the process of upskilling extra care staff with medication administration. The service has been training additional nine staff members to support with medication administration as needed.

In relation to the named consumer who rolled out of bed, documentation shows the consumer has not had any falls with injuries in the last 3 months. The provider acknowledges the consumer’s assessment post fall was not in line with the service’s policies and procedures and falls prevention and management have been incorporated into the education plan.

In relation to the consumer with wounds, the provider asserts multiple wound charts were created by different staff members for one wound due to their confusion in relation to the wound classification, specifically difficulty with differentiating pressure injury and incontinence associated dermatitis. Furthermore, one of the wounds that was an ulcer was incorrectly classified as a pressure injury. The incontinence associated dermatitis has resolved and staff was provided training on correct classification of wounds.

I acknowledge the provider’s response, improvement actions and additional information.

The provider acknowledges staff require actional training in wound assessment, and the process of monitoring of fluid intake requires improvement which has commenced following the assessment contact. As this evidence highly relevant to requirement 2(3)(a), I considered it in coming to my finding under Standard 2.

However, the evidence in the assessment team’s report does not indicate systemic issues in how the service identifies, mitigates and manages high impact risks associated with skin care, pressure injuries and hydration of consumers who are on fluid restriction.

The provider acknowledges one fall was not followed up in line with the expected standard of care. However, determining the effectiveness of managing high-impact risks of falls based on one fall incident and its management is not sufficient. The provider’s response and supporting evidence shows the service trends and analyses data which shows no consumers sustained injuries following falls in the last reporting period which shows risk of harm and injuries is managed effectively.

However, the provider did not identify, mitigate and managed risks associated with administration of time critical medications for at least 2 consumers for whom medications were frequently not administered within the prescribed time window. I acknowledge the provider referred the consumers to a general practitioner and, as a result the prescribed time window was increased. However, the provider’s monitoring systems have failed to identify systemic issues with administration of time critical medications. Furthermore, whilst the provider asserts there has been a significant improvement in team practice regarding all the medications administration across the service, no evidence was provided to support this claim.

Based on the reasons summarised above, I find requirement (3)(b) non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

As not all requirements within Standard 7 were assessed, the overall rating is Not applicable.

The assessment team recommended this requirement not met.

Whilst management described how they review staff mix regularly and staffing levels are above required care minutes, the assessment team found this does not enable delivery of safe and effective care.

Three consumers provided examples of how their needs are not being met due to insufficient staffing numbers. One consumer advised staff can take up to 30 minutes to respond to call bell which leads to episodes of incontinence. Two other consumers advised they often are not assisted with the shower at their preferred time.

Staff said the service does not have right mix of staff to administer medications on time and monitor provision of care. Morning medication round was observed to go over one hour. Two consumers prescribed time critical medications, had delayed administration by more than 30 minutes or early from the prescribed time for administration. In five days prior to the assessment contact, three shifts have not been replaced.

In response to the assessment team’s report the provider acknowledged findings in relation to medication administration and lack of trained staff to undertake this task. Prior to the assessment contact, the service was in the process of upskilling extra care staff with medication administration. Recruitment has been one of the key priorities for the service. In the first quarter of 2024 the service has significantly increased their care and clinical staff numbers.

The provider states, over the past six months, the service has experienced leadership difficulties due to ongoing turnover within the management team. As of January 2024, the service has a new set of management team with two members internally recruited as part of succession planning, possessing considerable knowledge of the organisation’s systems and processes.

In relation to the named consumer’s feedback about delayed call bell response time, the provider undertook a review of the call bell response times for a month prior to the assessment contact which showed 92% of the call bells have been answered in under 5 minutes.

I acknowledge the provider’s response and actions taken which commenced prior to the assessment contact. These actions include upskilling care staff to undertake medication administration tasks and working on a strategy to manage a workload by reducing the number of consumers allocated to each person administering medication.

Whilst 2 consumers reported they did not receive assistance with showering at the time of their preference, I note the care was being delivered at a later time during the day. The delivery and management of safe and quality medication management was impacted by ineffective planning of the workforce with the skills to administer medication and the provider has commenced an action plan to address this.

Based on the reasons summarised above, I find this requirement 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

This Quality Standard is assessed as non-compliant as one requirement has been assessed as non-compliant.

This requirement was found non-compliant following an assessment contact on 9 November 2023 where it was found risk management systems were not effective because clinical incidents and quality indicators were not analysed and trended to enable effective implementation of risk mitigation strategies.

The assessment team’s report provided evidence of actions taken by the service to address the non-compliance including weekly meetings with the quality team, monthly operational and governance meetings to analyse trends in incidents and continuous improvement activities. A new process has been implemented where management attend handovers to review quality of handovers and information being provided.

At the assessment contact undertaken from 29 February 2024 to 1 March 2024 the assessment team recommended requirement (3)(b) not met.

There are effective risk management systems and practices to identify and respond to abuse and neglect of consumers and supporting consumers live the best life they can. However, risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents were not effective.

Not all incidents were recorded, and incident data was not analysed for trends accurately. While medications, including time critical, were identified to be administered late on multiple occasions for a prolonged period of time, staff were not completing incident reports. Review and reporting of the medication incidents commenced at the time of the assessment contact.

Staff could not describe the high-impact of high-prevalence risks associated with the care of consumers. While incidents associated with high impact and high prevalence risks, such as falls and pressure injuries, were reported and discussed in the clinical governance meeting, the reports showed generic comments regarding trends.

Care documentation demonstrated, while staff support consumers to live the best life they can, risks and mitigating strategies were not consistently identified, assessed and documented.

In response to the assessment team’s findings the provider included information to demonstrate how the services utilises the High Acuity Risk Score (HARS) dashboard to identify high-risk consumers. Information about consumers who are identified as high-risk is shared with the team through handovers, daily meetings and has a reference folder at each nurse station for team members to access at any time.

The provider’s response included description of a range of clinical governance processes that are used to ensure consumers with high impact and high prevalence risks are monitored closely. These include clinical indicators dashboard to oversee clinical trends daily which assist staff to drive continuous improvements in a timely manner. The support team such as the Quality Advisor, Care Quality and Compliance team and the Area Manager also review these clinical dashboards weekly to provide another governance layer for the service to minimise any clinical risks. Registered Nurses have received education on the daily handover and the 10 at 10 meetings processes.

The provider acknowledges that the quality of the meeting minutes and benchmark reports was generic in nature. With the new management onboard, the service is expected to address this area of improvement. In relation to medication incidents, the service acknowledged the feedback during the assessment contact and commenced improvement activities.

I acknowledge the provider’s response, plan for continuous improvement and commitment to improve risk management systems and practices, including in relation to how incidents and its analysis are used to improve quality and safety of care and how information about high impact risks is recorded, trended, analysed and shared with all staff. However, improvement activities have not been closed on a plan for continuous improvement and have not been evaluated for effectiveness.

Based on the reasons described above, I find requirement (3)(d) 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)