Performance

Report

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| Name of service: | Lutheran Services – Cooinda Aged Care Centre |
| Service address: | 2 Cooinda Street GYMPIE QLD 4570 |
| Commission ID: | 5134 |
| Approved provider: | Lutheran Church of Australia - Queensland District |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 May 2023 to 17 May 2023 |
| Performance report date: | 21 June 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 Lutheran Services – Cooinda Aged Care Centre (**the service**) has been prepared by K. Reed, 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
* the provider’s response to the assessment team’s report received 07 June 2023
* other intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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 ensure there are sufficient staff to deliver safe, quality care and services.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

**Requirement 3(3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:**

**(i) is best practice; and**

**(ii) is tailored to their needs; and**

**(iii) optimises their health and well-being**.

The Assessment contact-site report contains information a named consumer was not supported during their end of life care as care documentation does not indicate the frequency of repositioning, pressure area care or continence aid changes. The Approved provider in its response refutes this information and included an email from the consumer’s family as evidence of the appropriate care given to the named consumer during their end of life care. While there were gaps in documentation relating to the frequency of pressure area care and the frequency of continence aid changes, it is my decision this does not reflect poor care delivery. Progress notes and End of life pathway documentation supports the named consumer was supported to be as pain free as possible and staff followed the requests from family when not delivering pressure area care as prescribed, which in my opinion is reflective of best practice palliative care. I have not given weight to the information relating to this consumer when coming to my decision.

Two consumer representatives provided feedback regarding the potential for a lack of care delivery to their consumer. This information was speculative and did not identify a lack of care delivery or impact to the consumer, rather it was information to support care may not be provided if representatives were not involved in care delivery. For one named consumer information was recorded to indicate a medication review needed to be requested three times. Progress notes (including medical officer review) were submitted as part of the Approved provider response which indicate consistent review of medications in a timely manner when any change in the named consumer’s condition occurred.

For another named consumer, the Assessment contact-site report includes information that suggests deficits in the documentation of repositioning charts and continence aid changes have resulted in negative outcomes to the consumer’s skin integrity. I note the Approved provider submitted a skin integrity completed on the consumer’s entry to the service in September 2022, I have no evidence to support a lack of documented pressure area care or continence aid changes has produced a negative outcome for this consumer and their skin integrity. While it is detailed in the Assessment contact report staff reported being unable to provide pressure are care to the named consumer due to time constraints, this has not been evidenced in Consumer outcome statements.

For a third named consumer, the Assessment contact-site report includes information the consumer does not receive frequent continence aid changes, pressure area care or repositioning due to staff workloads and the consumer’s inability to advocate for themselves. Wound care charts submitted by the Approved provider as part of their response indicates regular review, and monitoring of the consumer’s pressure injury. I am unable to determine a lack of completion of continence aid change, pressure area care checklist or repositioning charts have had an impact on the progress or healing of the consumer’s wound. Wound photos submitted as part of the Approved provider’s response indicates on 14 May 2023, the wound had decreased in size, and was clean in appearance.

I have reviewed information contained in the Assessment contact-site report alongside the Approved provider’s response and I am unable to draw a correlation to deficits in documentation relating to position changes and continence aid changes with a decrease in consumer skin integrity. I have considered for one consumer end of life care was delivered in accordance with their wishes, in conjunction with medical officer directives.

It is my decision, that information in the Assessment contact-site report and after review of the Approved provider’s response does not support a decision of Non-compliance and it is my decision this Requirement is Compliant.

**Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.**

The Assessment contact-site report includes information relating to two consumers with renal or cardiac failure who both have restrictions on the amount of fluid they can ingest daily. Neither consumer has a fluid balance chart to record their fluid intake. Apart from one consumer who stated their feet sometimes get swollen, there was no other impact identified for the consumers due to a lack of monitoring of their fluid intake.

The Approved provider in its response to this information has noted both consumers are cognitively competent, and both choose to monitor their own fluids. Medical officers for both consumers have not requested fluid balance charting. To support the consumers’ choices to monitor their own fluid intake, the Approved provider has held discussions with the two consumers and completed a Discussion of risk summary form for both consumers and care planning relating to Nutrition and hydration have been updated. While I acknowledge the consumers’ rights and wishes to monitor their fluid intake and the lack of concerns raised by medical officers or renal specialists, I note for one consumer documentation indicates some memory loss and therefore suggest ongoing monitoring of the consumer’s capacity to monitor their fluid intake. I am unable to establish a link between a lack of fluid balance charts and poor care outcomes for the two named consumers.

The Assessment contact-site report contains information relating to medication incidents for two named consumers, the Approved provider in its response has indicated there is no consumer at the service with that name and therefore is unable to comment regarding information contained in the report relating to this consumer. For the second named consumer who was administered another consumer’s medication in error on 27 February 2023, the Approved provider response indicates an incident report was completed and immediate actions were taken including contacting relevant parties and clinically monitoring the consumer. The incident was escalated to the Agency responsible for the staff member for internal investigation. A retrospective incident report was completed and submitted to the Serious incident response scheme. This information will be considered under Standard 8 Requirement (3)(d).

For a named consumer, the Assessment contact-site report includes information the consumer was commenced on an end of life pathway including the prescription of end of life medication, without consultation with their enduring power of attorney and concerns were raised by the consumer’s representative in relation to the reduction of anti-depressant medication.

The Approved provider in its response refutes this information. The Approved provider states the consumer was commenced on an End of Life Care Management Plan on 28 September 2022 as a case conference was held that day and this document is the organisation’s assessment for documenting advance care planning and consumer choices should they enter end of life so the service can support the consumer’s wishes. The end of life medication noted in the report was prescribed on 11 August 2022 as clinical staff were concerned regarding the consumer’s condition and requested pain relief be prescribed. A report submitted by the Approved provider as part of the response demonstrates the medication was not administered. The Approved provider notes the consumer is currently well and is not under an end of life pathway.

The Assessment contact-site report also contains information the family members raised concerns regarding the rapid reduction of the consumer’s antidepressant medication without consultation. Progress notes submitted by the Approved provider as part of its response demonstrates a discussion was held 02 May 2023, with the consumer’s enduring power of attorney requesting the medical officer review the consumer’s medication as the family were concerned it may be contributing to the weight loss and aggressive moods displayed by the consumer. The consumer was reviewed by their medical officer the following day (03 May 2023) and a reduction in medication occurred. Further progress dated 10 May 2023, demonstrate a case conference was held with registered staff, family members and two medical officers whereby the medication change was discussed, and it was noted the consumer seemed much unchanged following the reduction in medication. While I note family members raised concerns to the Assessment Team regarding the rapid reduction of the medication, a request was made by the family to reduce the medication and the service supported that by arranging a medical officer to review the medication. It is my decision the above information does not demonstrate a departure in the delivery of care and services.

While I acknowledge a medication incident occurred, it is my decision the incident was managed effectively. Other information relating to the lack of fluid balance charts, a consumer commenced on an assessment tool relating to the end of life wishes, the prescription of as required pan relief and the reduction of medication at the request of family does not support a finding of Non-compliance in this Requirement. It is my decision, through review of documentation submitted by the Approved provider, that the service is effectively managing high-impact and high-prevalence risks to consumers and therefore it is my decision this Requirement is Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Consumers and their representatives were satisfied with the meals and said they are served on time, of good quality, enjoyable, and there are alternative options available.

Consumers said they provide feedback about the meals to staff and provided examples of improvements made to meals in response to their feedback. Some consumers described how staff work with them to accommodate their specific dietary needs and preferences.

Staff understood consumers’ individual dietary needs and preferences, including those consumers with allergies or intolerances. The chefs said they receive feedback from consumers and accommodate consumers’ preferences.

The Assessment contact-site report identified that a rotating menu is developed by a dietitian and changes seasonally. Consumers choose their daily meals, and meal sizes, and can request alternate meals that are not on the daily menu. Consumers have 24-hour access to stocked kitchenettes. A dietitian and speech pathologist review and monitor consumers with dietary needs and changes.

The Assessment Team observed consumers seated together and being served lunchtime meals of varying sizes and options, and that consumers had snacks and drinks in their rooms.

It is my decision, based on information in the Assessment contact-site report, that this Requirement is 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. | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

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.

The Assessment contact-site report included information that consumers and representatives provided mixed feedback about sufficiency of staffing and that staff reported there were insufficient staff to meet consumers’ needs.

Consumer feedback included personal care delivery can be ‘hit and miss’ and that staff were ‘rushed’ and had too many competing priorities resulting in the consumer stating staff prioritised other consumers’ care delivery over them. One of the consumers said their showering preferences were not met and they were woken either too late or too early; they said previously their breakfast had been served while they were in the shower and that it had gone cold before they could eat it.

The Assessment Team observed staff having difficulty managing competing consumer care priorities and leaving consumers for long periods of time without assistance. For example, a consumer was observed in distress while a staff member sought assistance from a care staff member; the consumer was left unattended for approximately 15 minutes and was walking through the hallway of the service crying.

A number of care staff stated they did not have enough time to complete all assigned tasks during their shift and were unable to spend individualised time with consumers. Staff said they did not have time to implement strategies documented in a consumer’s behaviour support plan. One care staff member said they were frequently rushed when providing care and that consumers waited extended periods of time when the service was short staffed, sometimes waiting up to one hour.

Staff said they did not have sufficient time to complete their documentation and that aspects of care delivery, for example wound care, were often carried over to the following shift. Clinical staff said it was not unusual for incidents to occur due to staff rushing their work.

The Assessment contact-site report includes information that for a number of consumers, care documentation failed to demonstrate that consumers received care such as continence care and repositioning in accordance with their identified needs.

The Approved provider in its response stated the service is appropriately staffed to meet consumers’ needs. There were strategies to address unplanned leave that included the use of agency staff, shift extensions and redeployment. Examples of strategies used to increase recruitment and retention of staff were provided and included the recruitment of 21 staff across various service areas in the previous six months.

Call bell data was submitted for a five month period demonstrating that 85% of consumers’ requests for assistance were answered in less than 10 minutes and that 94% were responded to in less than 20 minutes; this however leaves a significant number of consumers waiting an extended period of time to be attended.

With respect to incomplete care documentation, while I am not persuaded that this necessarily constitutes a failure in care delivery, I am of the view that staff have consistently reported being unable to complete documentation due to time constraints and this does have the potential to impact care delivery.

Further, the response includes additional contextual information that clarifies information in the Assessment contact-site report. The report included information that a consumer missed a medication as a result of inadequate staffing and that another consumer was not adequately monitored when they experienced a health related incident. The Approved provider asserts that these incidents were not reflective of inadequate staffing; I accept this.

However, consumers have provided examples of how their care has been compromised, staff reported being rushed and unable to complete their duties, the Assessment Team observed consumers experiencing delays in staff attending to their needs and care documentation was inconsistently completed. Additionally, the Approved provider’s response included information that on a significant number of occasions call bell response times exceeded 20 minutes. I am satisfied that staffing is not consistently supporting the delivery of safe, quality care and I find Requirement 7(3)(a) Non-compliant.

**Requirement 7(3)(c) The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.**

**Requirement 7(3)(d) The workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards.**

I find Requirements 7(3)(c) and 7(3)(d) Compliant. The service had systems in place to ensure that staff completed an orientation program, a training program was in place and staff were competent and had the necessary qualifications to deliver care. Consumers and representatives spoke positively and felt staff were competent and had the required skills for their roles.

Management said staff were required to submit evidence of their qualifications during the recruitment process and that national criminal history checks and registrations were recorded by the organisation; a review of the register demonstrated the register was current.

Staff described the training, support, professional development, and supervision they received, including during orientation and on an ongoing basis. The training program was varied and included mandatory reporting, Code of Conduct, Aged Care Quality Standards, hygiene, and safety. Prior to commencing work, new staff participated in on-site training that addressed manual handling, fire safety and infection control. Additionally, new staff received a minimum of two ‘buddy’ shifts where they worked with their supervisor or clinical lead; additional ‘buddy’ shifts could be requested when a need was identified.

# 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. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Requirement 8(3)(d) Effective risk management systems and practices, including but not limited to the following:

(i) managing high impact or high prevalence risks associated with the care of consumers;

(ii) identifying and responding to abuse and neglect of consumers;

(iii) supporting consumers to live the best life they can

(iv) managing and preventing incidents, including the use of an incident management system.

The Assessment contact-site report contains information the service was unable to manage and prevent incidents, and management failed to demonstrate effective management of risks and incidents, including adhering to mandatory reporting requirements. The report includes information relating to three consumers and medication incidents and the lack of identification these incidents required reporting to the Serious incident response scheme as incidents of neglect.

The Approved provider has acknowledged improvements could be made around senior clinical staff knowledge on what medication incidents are considered reportable. The organisation has amended the electronic medication incident form to include a prompt for staff to determine if the incidents are reportable. The education session relating to reportable incidents has been updated to include more information relating to neglect and medication errors. A separate education session will be delivered for managers and senior clinicians relating to ‘medication error versus neglect’.

For one named consumer it is noted the consumer received medication to which they had an allergy, the Approved provider refutes this information and states the consumer had a sensitivity to the medication, the medical officer was contacted and provided advice the consumer was to receive the medication as they were at end of life. This was confirmed by progress note entries submitted by the Approved provider as part of their response.

Information contained in the Assessment contact-site report relating to many representatives have not been informed when incidents have occurred has been refuted by the Approved provider. The one named consumer whose representative provided feedback they were not contacted following a medication incident, the Approved provider noted the representative was not the consumer’s enduring power of attorney or primary contact and therefore was not required to be contacted.

For a named consumer with the ability to mobilise independently, the Assessment contact-site report contains information the service failed to adequately assess a consumer’s ability to reside safely at the service without risk mitigations strategies in place due to their suicidal ideations. The service is made up of multi-story buildings where consumers have free access to move between buildings and levels at their own discretion.

The Approved provider noted in its response completed a risk assessment and update to the consumer’s behaviour support plan occurred prior to the completion of the Assessment contact-site visit. The service assesses each consumer entering the service for dignity of risks or apparent risks, this was supported by a Balcony risk assessment provided for a new consumer and contained within the Approved provider’s response.

The Approved provider refutes information relating to the service having three separate incident registers and some incidents appear to have been missed, and states the organisation utilises one incident reporting system for all consumer incidents. The Approved provider acknowledged improvements are required to identify which medication incidents require escalation and reporting, and medication incident reports have been amended to include a prompt for staff to consider the reporting requirement of the incident.

Information recorded in the Assessment contact-site report states the number of medication errors has not systematically reduced. The Approved provider has refuted this information and provided statistics and an improvement report to support 23 medication incidents occurred in April 2023 and 12 incidents occurred in May 2023.

In coming to my decision regarding compliance in this Requirement, I have considered my compliant decision for Requirement 3(3)(b) in relation to effective management of high-impact and high-prevalence risks. I have taken note of the actions the service has taken to identify medication incidents that require escalation and reporting to be comprehensive and sustainable, and I have considered the actions taken by the service in relation to the consumer with suicidal ideations and the processes in place for risk assessments to be completed for consumers on entry to the service to be comprehensive and effective.

It is my decision the organisation does have processes to manage and prevent incidents and the incident management system is effective and therefore it is my decision this Requirement is Compliant.

Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:

1. antimicrobial stewardship;
2. minimising the use of restraint;
3. open disclosure.

The Assessment contact-site report contains information the service was unable to demonstrate effective implementation of the documented clinical governance framework leading to adverse outcomes for consumers. The report states inconsistent incident management with deficiencies in identifying and reporting serious incidents such as mismanagement of medications. The report also states the service could not demonstrate it is effectively managing care delivery with systemic breakdowns identified in the delivery of safe care to consumers.

I have previously considered the delivery of care and services to consumers when making my decision for Requirement 3(3)(a) and found the service compliant in this Requirement, and I could not draw a link between the non-completion of care documentation and negative outcomes to consumer care. I also noted the named consumer was supported with appropriate end of life care.

I acknowledge medication incidents have occurred at the service and I also acknowledge gaps in understanding which medication incidents required reporting and escalating to the Serious incident response scheme. However, I am satisfied with the actions taken by the Approved provider to mitigate the risk of this re-occurring, and it is my decision the incidents were effectively managed at the time of occurring.

The Approved provider refutes the information in the Assessment contact-site report relating to gaps in incident management related to unplanned leave and the transition to an electronic platform to record incidents. The Approved provider has acknowledged improvements are required in the understanding of reporting incidents and dates the transition to an electronic platform occurred in 2022 and did not cause miscommunication around clinical care.

I am not convinced deficits in identifying medication incidents that require reporting to the Serious incident response scheme as sufficient evidence to support the systemic breakdown of the service’s clinical governance framework. Other concerns relating to clinical care delivery have been mitigated by my decision Requirements 3(3)(a) and 3(3)(b) are compliant.

It is therefore my decision, Requirement 8(3)(e) is 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)