Performance

Report

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| Name of service: | May Shaw Aminya |
| Service address: | 19 Cameron Street SCOTTSDALE TAS 7260 |
| Commission ID: | 8023 |
| Approved provider: | May Shaw Health Centre Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 April 2023 |
| Performance report date: | 1 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 May Shaw Aminya (**the service**) has been prepared by N Wapling, 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 4 May 2023
* Other relevant matters taken into account in developing this performance report include:
  + The service was issued a Directions Notice in August 2021 following a finding of non-compliance with the Quality Standards in 3(3)(b).

# Assessment summary

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| Standard 3 Personal care and clinical care | 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.

* Requirement 3(3)(b) – the approved provider ensures effective management of high impact or high prevalence risks including strategies and support to manage behaviours with the impact on other consumers in the service, prescribed psychotropic medications in relation to the consideration of chemical restrictive practices, monitoring and management of consumers assessed at risk of weight loss / malnutrition and the management and monitoring of consumers post falls.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

Findings

I have assessed the Quality Standard as Non-compliant as I am satisfied Requirement 3(3)(b) is Non-compliant:

This Requirement was found non-compliant following an Assessment Contact, 16 June 2021.

The service was unable to demonstrate:

* Management of high impact or high prevalence risks and complex clinical care in relation to the management of falls, behaviour, weight loss and diabetes.

During the Assessment Contact on 18 April 2023, the service demonstrated that some actions were implemented in response to the issues identified during the assessment contact in June 2021. However, not all high impact or high prevalence risks in the service were effectively managed. The Assessment Team found the service was unable to always demonstrate the management of high impact or high prevalence risks was in line with the service’s process and procedures, particularly in relation to behaviour management, weight loss/malnutrition and post falls management of consumers.

The Assessment Team’s evidence named 3 consumers, one with behaviours that impacted other consumers, one assessed at high risk of malnutrition and one who’s post falls management was not monitored consistently according to the service’s falls clinical pathway.

A consumer with behaviours that impacted other consumer’s well-being did not have all strategies staff said were effective documented in their behaviour support plan. This consumer was prescribed antipsychotic medication, however this was not recognised as chemical restraint and no informed consent obtained. Staff said the consumer was prescribed the medication to manage symptoms of agitation and anxiety. Management said the service had not considered a specialist behaviour assessment to assess these behaviours. In addition, the service’s psychotropic medication register identified consumers who were prescribed antipsychotic medication, no diagnosis for their use was documented.

A consumer assessed as being very high risk of malnutrition did not have records of food intake completed consistently and monthly weight recordings were missing in three of the eight months of records, the dietitian review of this consumer was July 2021. This was not in line with the service’s procedure, and plan for continuous improvement (PCI) recommendations that consumers assessed at a high risk of malnutrition using the service’s screening tool to consider specific interventions. These include a dietitian review, weekly weight recording and recording of food intake. Staff were able to identify strategies for unplanned weight loss monitoring and management and that this consumer required encouragement to eat meals and is receiving nutritional supplements.

A consumer who had an unwitnessed fall did not have neurological observations recorded as described in the service’s falls clinical pathway. Staff were able to identify falls as a high risk, the preventative strategies and management of a consumer post a fall.

Care documentation relating to a consumer named in the previous report had insufficient information for the consumer to self-manage their diabetes care. Care planning documentation showed diabetes care is now appropriate and safe.

The service provided evidence of staff education relating to dementia education planned for staff in June 2023, and for food and hydration without a date of when this occurred.

The Approved Provider provided a written response with information and documentation including reports, registers, education records, care plans and progress note entries, and a care pathway. Actions include a planned case meeting for the named consumer with behaviours, a dietitian review that has occurred since the Assessment Contact for the named consumer assessed at high risk of malnutrition and a review of dietitian services overall, a review of medications prescribed as chemical restraint and development of a new falls pathway. In addition a Registered Nurse has commenced implementing improvements to the management of the service’s processes, a clinical nurse educator is commencing in May 2023 and an electronic medication system is being introduced in July 2023.

I have reviewed and considered all of the information provided. While I note the Approved Provider has taken action in response to the Assessment Team’s findings, there were a number of deficits identified in how the service manages high impact or high prevalence risks for a number of consumers. While I am satisfied the Approved Provider has commenced implementing improvements in relation to behaviours, weight loss/malnutrition and post falls management of consumers however, these actions have not been fully implemented, evaluated, or embedded. Therefore, I have come to a view and am satisfied this Requirement 3(3)(b) is not 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)