Performance

Report

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| Name of service: | Michael Lee Centre |
| Service address: | 80-82 Henley Street COMO WA 6152 |
| Commission ID: | 7223 |
| Approved provider: | Meath Care (Inc) |
| Activity type: | Assessment Contact |
| Activity date: | 25 August 2022 |
| Performance report date: | 05 October 2022 |

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 [Home Name] (**the service**) has been prepared by T Wilson, 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; the Assessment Contact 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 15 September 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **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.

* Requirement 3(3)(b) – ensure that pressure injuries are identified in a timely manner and pressure area care is provided as scheduled. There is specific information on physical restraints for staff especially when it involves physical contact and ensure risks behavioural are assessed and monitored and responded to appropriately.
* Requirement 8(3)(d) – ensure all incidents are reviewed and risk assessed appropriately and risk mitigating strategies applied and monitored for effectiveness and ensure that risk ratings are appropriate the apportioned risk.

# 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

As requirement 3(3)(b) has found to be Non-complaint the overall rating for this standard is Non-complaint.

The Assessment Team found the service does not manages high impact or high prevalence risk associated with each consumer effectively. This includes a consumer at risk of harm from another consumer’s responsive behaviours, preventing and managing pressure injuries, managing hydration and nutrition including weight loss or minimising restrictive practices.

* Pressure injuries were not being identified until they are advanced and when they are identified they are not being classified correctly.
* The strategies to manage a consumers behaviour are not effective in reducing the risk to another consumer.
* Consumers are not always referred to a dietician when weight loss is identified, and despite providing supplements to consumers the service is not seeking advice as to whether they are suitable.
* Restrictive practice is used despite being ineffective.

The service provided a comprehensive response refuting that requirement 3(3)(b) is not met and which included pointing out several inaccuracies in the Assessment Team’s report. Their evidence includes:

* The service provided repositioning charts to attempt to show that repositioning was completed 2 hourly following the period identified by the Assessment Teams report;
* A consumer with weight loss only lost weight as they were placed on medication to prevent fluid accumulation and others that were said to be palliative have improved and been referred to a dietician;
* Wound training has been completed as planned and was only delayed due to COVID 19;
* Effective strategies were used to reduce behavioural risks to other consumers; and
* The physical restrictive practice was monitored for effectiveness and the towel mentioned by the Assessment Team was not the restraint.

I have considered the response and evidence from the provider along with the information contained in the Assessment Team report and whilst I do acknowledge there are some inconsistency in the Assessment Team’s report, I agree with Assessment Team the provider is not complaint with this requirement.

I have considered the evidence provided in relation to the pressure injury that was identified when it was at stage 2 not at stage 1 when it would be expected to be identified. In addition, leading up to the date pressure injury of the sacrum, the repositioning charts show that pressure area care was not always provided two hourly, especially when the consumer was not in bed but they were in a comfort chair which would put pressure on the sacrum. Whilst there were some entries for the chair they are inconsistent and so it is not clear whether pressure area care has or has not been provided. Nor was there any evidence provided to show that the pressure injury was discovered prior to developing into a stage 2 pressure injury despite staff conducting skin assessments when providing assistance with daily living.

In relation to the physical restrictive practice, whilst I acknowledge there is a consent completed, I do not consider the information provided to staff in the consent form adequately provides staff with the information on exactly what they restraint is, or how to apply it. Whilst it says for staff to ‘take and hold’ their hands and release every 15 minutes, there is no instruction for staff on how firm this should be or when to let go. Whilst I agree with the provider there is no mention of a towel as the restraint, there is also no information to tell staff how to use the towel when they did use one. There is a fine line between a physical restraint for consumers safety and wellbeing and staff using force with a consumer. I was not provided sufficient evidence to show there is not enough information to guide staff on using the restraint effectively or whether they were effectively monitoring the restraint when it was used or whether using this restraint has an impact to the consumer.

In relation to the behavioural incidents and consumers being at risk I considered the evidence provided in requirement 8(3)(d) and I do not consider the strategies being used are effective to reduce the risks for each consumer. Following the first incident the strategy was half hourly sighting charts and following the second incident the only other strategy implemented was an alarm for one consumers door. This did not stop one consumer interfering with the other consumers where no strategies were employed to stop that behaviour.

Accordingly, I am satisfied that 3(3)(b) is non-complaint.

I am satisfied that requirement 3(3)(d) is compliant.

The service demonstrated how deterioration or change in a consumer’s condition is recognised and responded to in a timely manner though a range of systems and processes such as handover, progress notes, incident reports, clinical charts and feedback about a consumer’s condition. Review of documents evidenced input from the multi-disciplinary team when deterioration was noted.

# 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

As requirement 8(3)(d) has found to be Non-complaint, the overall rating for this Standard is Non-complaint.

The Assessment Team found the service’s risk management system and practices are not effective in the management of high impact and high prevalence risks associated with consumer care or preventing incidents occurring, in relation to the management of high impact behaviours, pressure injuries, and unplanned weight loss. Staff are not demonstrating the early identification of risk which is impacting the ability of the service to manage high impact high prevalence risks.

* Five consumers at risk of pressure injury or unplanned weight loss did not have their risks identified and strategies implemented to reduce the risks to them.
* One consumer was found to have been physically assaulted twice by the same consumer where effective strategies were not implemented to reduce the risk of further incidents putting the consumer at risk of ongoing harm.
* Another consumer displaying responsive behaviours and subject to a restrictive practice did not have effective strategies implemented following behavioural incidents and the current strategies were not evaluated for effectiveness.
* The service provided a substantial amount of evidence to consider to support the requirements as they believe this requirement is compliant. The provider asserts that they effectively manage high impact high prevalence risk and both consumers involved in the behavioural incidents have been managed effectively.

I have considered the response and evidence from the provider along with the information contained in the Assessment Team report and I agree with Assessment Team the provider is not compliant with this requirement.

Whilst the incident was reported correctly and the incident forms completed following the first incident, the behaviour strategies were not reviewed and the only strategy following the incident was to watch them. Whilst I understand that there is a half hourly sighting chart, the information provided by staff was ‘they can’t watch them all of the time’ is relevant.

The incident was assessed as unlikely to occur, with no review of behavioural strategies, yet it did occur again one month later. The information I also draw from is the information sent in from the provider which showed the perpetrator was interfering with others and in the progress notes it was stated on several occasions that they were watching the victim closely.

On the second occasion again, the incident was only rated as it could possibly occur(every 1-2 years) which is not congruent with two consumers, one who watches another closely and has previously been aggressive towards the person that an incident could only possibly occur again. Also, the second incident occurred in a communal area not somewhere where the consumer was encroaching on their personal space.

The strategy that was in place, the half hourly sighting charts did not work so additional measures need to be investigated to ensure the safety of both consumers in the future. It is noted that the both consumers have now been referred to Dementia Support Australia following the Assessment Contact. However, at the time of the visit I do not consider that all avenues to keep both consumers safe have been explored.

I have considered the management of pressure injuries and weight loss in conjunction with the information provided in requirement 3(3)(b) and whilst the service does have some things in place to manage these risks, the information provided showed that once a consumer is considered as palliative, no matter what stage, they were no longer being assessed as requiring to be reviewed about their nutritional needs. Whilst this has now been rectified, at the time of the Assessment Contact that was not occurring.

Accordingly, I am satisfied requirement 8(3)(d) is non-complaint.

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)