

**Performance Report**

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| Name: | Ozcare Innisfail |
| Commission ID: | 5076 |
| Address: | Warrina St/ Tulip St, Goondi, Queensland, 4860 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 29 October 2024 to 31 October 2024 |
| Performance report date: | 22 November 2024 |
| Service included in this assessment: | Provider: 952 Ozcare Service: 3433 Ozcare Innisfail |

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 Ozcare Innisfail (**the service**) has been prepared by Kimberley 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others
* the provider’s response to the Assessment Team’s report received 20 November 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 5** Organisation’s service environment | **Not applicable as not all Requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all Requirements were 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 care of consumers with high-impact or high-prevalence risk needs to be effectively managed.

# 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

The service was found to be noncompliant in this Requirement following an Assessment contact - site conducted on 12 and 13 March 2024 relating to the service’s inability to manage high impact and high prevalence risks associated with consumer care including unintentional weight loss, behaviour management, falls, diabetes management and time sensitive medication.

While improvement actions were implemented by the service, ongoing deficits were identified relating to the management of diabetes, time sensitive medication, and incident reporting.

In relation to diabetes management, consumers had individualised diabetic management plans in place, blood glucose levels were recorded in accordance with directives and staff shared an understanding of signs of high and low blood glucose indications. However, for one named consumer feedback was provided from their representative that their diabetes management was not managed effectively by the service and documentation evidenced poor diabetes management by staff at the service. The named consumer returned to the service following hospitalisation for deterioration on 28 October 2024. Parameters for blood glucose readings included instructions to contact the consumer’s medical officer if blood glucose readings were higher than 15mmol/L. A blood glucose reading on 30 October 2024 at 7.00am was recorded as 16.9mmol/L, no actions were recorded to address the named consumer’s elevated blood glucose level despite the consumer having clear directives and recent return from hospital. The consumer’s medical officer was not contacted by registered staff until feedback was provided by the Assessment Team. The consumer’s blood glucose readings continued to rise and were recorded as 20.3mmol at 4.30pm, the named consumer was noted to be drowsy and required transfer to hospital. The management of the named consumer’s diabetes was not in accordance with directives, did not support effective management of the risk of high blood glucose levels and this was not identified by the service’s monitoring processes.

The Approved provider in its written response to the Assessment contact report has provided further information relating to the named consumer as noted above, including registered staff attempting to contact the named consumer’s medical officer following their increased drowsiness when their 4.30pm blood glucose reading was taken, to report the consumer’s high blood glucose readings. While progress notes confirm the consumer was transferred to hospital following the 4.30pm high blood glucose reading and decrease in consciousness, there is no evidence to support how the consumer was supported or monitored or actions taken by staff to address the risk to the consumer between 7.00am and 4.30pm. Given the consumer recently returned from hospital following an episode of severe hyperglycaemia and had medication changes to treat their diabetes, it is reasonable and best practice for staff to monitor the consumer closely. This was not supported by documents submitted by the Approved provider in its response.

Actions taken to address previous deficits in the management of time sensitive medication included the production of a report to identify when time sensitive medication was administered 30 minutes outside of prescribed administration times. While the report identified when medication was administered outside of therapeutic timeframes, this did not prompt the recording of incident reports. For example, 22 incidents of late or early administration had been identified for four consumers in the preceding two weeks to the assessment contact visit, and one incident report had been completed. This is not in accordance with feedback provided by management that an incident report is to be completed when time sensitive medication is administered incorrectly. While registered staff were aware of the requirement to complete incident reports, they advised this does not always occur. Furthermore, 22 incidents of time sensitive medication being administered incorrectly over a two week period, demonstrates processes including education and increased monitoring have been ineffective in addressing the previously identified deficits.

The written response from the Approved provider does not refute the information relating to time sensitive medication and acknowledged newly recruited registered staff and agency staff have taken longer to complete medication administration rounds, and these staff members are responsible for incidents relating to time sensitive medication. Additional education has been provided to the registered staff involved. A registered staff responsibility chart was submitted as part of the Approved provider’s response which highlights time sensitive medication are a priority during the shift. The Approved provider noted time sensitive medication have been discussed at fortnightly registered staff meetings since March 2024. The Approved provider’s response did not address the lack of incident reports relating to the incorrect administration of time sensitive medication. Despite the awareness of staff to the importance of time sensitive medication, the daily monitoring by clinical staff and the implementation of a reporting function, consumers continue to receive their time sensitive medication outside therapeutic timeframes, which increases risk with consideration to their diagnosed condition.

Access to physiotherapy services is facilitated with two physiotherapists onsite on weekdays. Physiotherapists assess consumers following a fall, provide education to staff on falls prevention strategies, and update consumers’ mobility plans. Group exercise sessions were provided, and one on one support assistance was provided in a reablement and wellness program. For one named consumer assessed as at high risk of falls and prescribed anticoagulant medication, progress notes on 26 October 2024, indicate the consumer ‘banged his head on door’, however an incident report was not created, and observations were not documented. The report noted the named consumer also sustained a fall 10 October 2024, and documentation does not support an incident report was created.

The Approved provider in its response refutes the evidence contained in the Assessment contact report in relation to falls. Progress notes submitted as part of the response indicated the named consumer above did not have a fall 10 October 2024, however, was reviewed by the physiotherapist as an initial consultation rather than a falls follow-up consultation. Documentation supported the consumer was reviewed by the physiotherapist following subsequent falls. In relation to an incident report not being completed following the consumer hitting their head, the Approved provider noted this was not a fall and did not require an incident report and submitted progress notes that evidenced the consumer’s observations were taken and were within normal ranges. While the event of the consumer hitting their head may not meet the threshold of a fall incident, where a consumer is receiving anticoagulant medication and at risk of haemorrhage, it is reasonable to expect an incident report to record the event, rather than a progress note entry.

Actions taken by the service to address deficits relating to unplanned weight loss included the monthly support of an onsite dietitian. Consumers of concern were reviewed in March 2024, and ongoing monthly review continues. Food at the service has been fortified following the employment of a new chef and reviewed menu. Weekly weights and the implementation of food and fluid charts were introduced for consumers with unintentional weight loss. While the following actions were implemented it was noted for one named consumer who lost 4.6kgs of weight between July and September 2024, documentation did not support the named consumer had been referred to a dietitian, that weekly weighing and flood and fluid charts had been implemented or that the service’s monitoring processes had identified the consumer’s weight loss.

In relation to the named consumer with weight loss, the Approved provider in its response stated the consumer had been reviewed by a dietitian in August 2024 and was trialled with supplement drinks three times daily. The Approved provider noted the consumer’s representative was informed of the weight loss in September 2024. The response by the Approved provider did not contain evidence of weekly weights or food and fluid charts for the named consumer, as per the service’s processes.

In coming to a decision regarding compliance in this requirement, I have considered both the Assessment contact report and the Approved provider’s response. The service has been noncompliant in this requirement since April 2024 and has implemented actions relating to deficits identified at the Assessment contact March 2024. The Approved provider refutes there are deficits in care or ongoing high risk to consumers. While the service has implemented actions to address previous deficits, risks relating to diabetes and time sensitive medication has not been addressed sufficiently and consumers remain at risk. It is my decision the service is required to assess rectification actions for their effectiveness, and therefore this requirement remains noncompliant.

# Standard 5

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| Organisation’s service environment |  |
| Requirement 5(3)(b) | The service environment:1. is safe, clean, well maintained and comfortable; and
2. enables consumers to move freely, both indoors and outdoors.
 | Compliant |

Findings

The service was noncompliant in this Requirement following an Assessment contact on 12 to 13 March 2024 related to areas of the service not being well maintained and consumers residing in the memory support unit were unable to move freely within the service or access outdoor areas.

The service took actions to address these deficits which included the removal of debris from outdoor areas, maintained a gardening schedule to ensure the safety of garden areas, provided education for staff in relation to maintenance requests and increased lifestyle staff in the memory support unit to assist in supervision of consumers in outdoor areas.

Consumers provided positive feedback in relation to their access around the service and the response to any maintenance requests. The service was observed to appear clean and tidy. Gardens were well maintained with plants and greenery. Cleaning staff were observed cleaning common areas and consumers’ rooms. Additional staff have been rostered to the memory support unit to support consumers’ movement and access to outdoor spaces.

Maintenance records indicated both a reactive and preventative maintenance schedule was in place. Records indicated there were no outstanding maintenance requests.

Based on the information recorded above it is my decision this Requirement is now compliant.

# Standard 8

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| Organisational governance |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:1. information management;
2. continuous improvement;
3. financial governance;
4. workforce governance, including the assignment of clear responsibilities and accountabilities;
5. regulatory compliance;
6. feedback and complaints.
 | Compliant |
| 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 |

**Findings**

**Requirement 8(3)(c)**

The service was noncompliant in this Requirement following an Assessment contact on 12 to 13 March 2024 related to deficits in information management, continuous improvement, regulatory compliance, and feedback and complaints.

The service took actions to address these deficits and improvement actions included the introduction of an electronic care management system, the continuous improvement plan was maintained, an organisation wide consumer body was introduced with consumers invited to participate, and access was provided to the organisation’s electronic feedback and complaints system.

Despite these improvement actions deficits were identified in this requirement in relation to information systems and continuous improvement. The Assessment contact report recorded items listed as closed on the continuous improvement plan had not been evaluated as effectively implemented, including improvements to the management of consumers with diabetes and the implementation of the electronic care management system. Despite staff attending training in the use of the electronic system, deficits remain in the recording and completion of incidents. Monitoring of this improvement activity failed to identify staff were not complying with diabetic management plans, impacting the care and risk to diabetic consumers and incidents were not consistently recorded to decrease the risk of reoccurrence.

The Approved provider in its response refutes the statement relating to the ineffectiveness of its information systems as an improvement action. The Approved provider states small discrepancies are expected as part of the rollout of a new electronic care system, particularly with new staff. The Approved provider submitted examples of completed incident reports to demonstrate the organisation’s expectation that incident reports ‘paint a picture’ of the incident rather than ensure every check box is completed. The Approved provider also refutes the closing of the action item relating to the implementation of the electronic care system and states ongoing support and training to staff is identified and monitored daily.

In relation to continuous improvement actions relating to diabetic management plans, the Approved provider refutes the statement relating to the closing of this improvement item without an effective evaluation of the implementation of the action. The improvement action related to the implementation and review of diabetic management plans and the updating of care plans with specialised instructions, this action was completed and therefore closed out on the continuous improvement plan.

Actions taken to address deficits relating to regulatory compliance and feedback and complaints have been effective.

In coming to a decision regarding compliance in this requirement, I have reviewed the Approved provider response alongside the Assessment contact report. I have given weight to the number of improvements actioned and completed for this requirement and consider the deficits relating to incident recording and diabetic management plans is more relevant to requirement 3(3)(b). Therefore, it is my decision this requirement is compliant.

**Requirement 8(3)(d)**

The service was noncompliant in this Requirement following an Assessment contact on 12 to 13 March 2024 related to ineffective risk management systems and a lack of understanding relating to serious incidents and their escalation process.

The management of high-impact and high-prevalence risks was not effective. Consumers received time sensitive medication outside therapeutic timeframes, despite improvement actions including increased monitoring of medications including the production of a report to identify errors. Despite a completed improvement action to improve information and guidance for staff in diabetic management plans, staff did not follow this guidance. Monitoring processes in place at the service did not identify these deficits.

The Approved provider in its response to the Assessment contact report states the service supports 23 consumers with diabetes, all these consumers had diabetic management plans in place and the Assessment contact report identified one consumer whereby staff did not follow the management plan in place.

The Assessment contact report included information recorded incidents lacked detail information which had not been identified by the monitoring of the electronic system by management. While the electronic system has the capacity to record incidents and initiate reporting to the Serious incident response scheme, the system relies on the correct completion of incident reports to support this process. Incidents were not completed correctly or for each incident and therefore the service was at risk of not escalating incidents accurately.

The Approved provider in its response documents that staff omitted to use the ‘not applicable’ classification for incidents when analysis of the incident occurred, in the context of the requirement to escalate to the Serious incident response scheme. The Approved provider stated daily review of incidents to ensure the correct classification of incidents identified no events were missed that would have constituted escalation due to staff not completing all check boxes. The Approved provider acknowledged the identification of incorrect time sensitive medication could constitute neglect if these medications were consistently missed or late, however the Approved provider rejects these incidents are reflective of the service’s ability to identify and respond to serious incidents.

Rectification actions to address previous noncompliance in this requirement included the review of progress notes by clinical management staff to ensure incidents were recorded appropriately. This action has not been effective as incident reports were not completed when errors occurred, for example time sensitive medication. Management committed to the completion of retrospective medication incidents reports for consumers who were administered time sensitive medication incorrectly.

In coming to a decision regarding compliance in this requirement, I have reviewed the Approved provider response alongside the Assessment contact report. I have considered improvement actions completed to address previously identified deficits in this requirement, I have also considered the organisation’s commitment to improvements including the recruitment, training and support of staff, the implementation of clinical and medication management systems. It is my decision there were deficits in the management of high impact risks to consumers, however these deficits relate to staff practices rather than an organisational governance deficiency and therefore are more relevant to the noncompliance decision for requirement 3(3)(b). Therefore, it is my decision this requirement 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)