Performance

Report

**1800 951 822**

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| Name: | Palm Lake Care Toowoomba |
| Commission ID: | 5784 |
| Address: | 149 Hogg St, Cranley, Queensland, 4350 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 5 December 2023 |
| Performance report date: | 4 January 2024 |
| Service included in this assessment: | Provider: 6794 Palm Lake Care Operations Pty Ltd  Service: 22950 Palm Lake Care Toowoomba |

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 Palm Lake Care Toowoomba (**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 (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 07 December 2023 and 22 December 2023
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all Requirements were assessed |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **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 risks associated with consumers requiring time sensitive medication needs to be effectively managed.
* Consumers at risk of choking require supervision and appropriate utensils to reduce the risk of choking.

# 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. | Compliant |

Findings

Consumers and representatives confirmed they were included in and were satisfied with the service's assessment and care planning processes. Care documentation included relevant assessment and risk identification such as falls, changed behaviours, skin integrity, infectious conditions, and specialised care needs. Registered staff described the assessment and care plan development processes that identified risks to the consumer's health, safety, and well-being.

Care documentation was reviewed for 10 consumers, which evidenced the service’s assessment and planning processes identified consumers' needs, goals and preferences and any related risks to their health and well-being. The service used an electronic care management system, which guides registered staff to assessments to be completed as part of the initial and ongoing consumer assessment process. Registered staff confirmed the outcomes of assessments are documented in care plans and discussed with the consumer and representative. Care and registered staff advised they had access to consumer documentation which guides them in identifying consumers’ preferences. The organisation had policies and procedures to guide staff practice regarding consumer assessment and care planning.

This Requirement is 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 |
| 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

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

The high impact risks for consumers including pressure injuries, weight loss and pain were managed effectively by the service. Monthly clinical risk meetings were held to discuss the management of risk to these consumers, and discussions were held during daily handover for all staff in relation to risks to consumers.

The impact and risk for consumers requiring time sensitive medication and consumers with swallowing difficulties was not managed effectively. Medications have not been administered as prescribed in a timely manner. Consumers did not receive time sensitive medication as prescribed. Supervision for a consumer with swallowing difficulties was not occurring to mitigate the risk of the consumer choking.

For one named consumer who experienced pain following a fall, strong pain relief was unable to be administered as the prescription for the medication had not been filled. The consumer was subsequently sent to hospital for pain management.

The Approved provider in its response received 07 December 2023, acknowledged the named consumer was sent to hospital to address pain concerns as staff were not able to locate the consumer’s medication chart. The Approved provider committed to actions to implement a clear process when a consumer enters the service or returns to the service following external appointments or hospital admissions, to ensure information is uploaded into the electronic care system and is communicated to the onsite team in a timely and comprehensive manner. An additional response was provided by the Approved provider 22 December 2023, in relation to the named consumer and their pain management. The Approved provider in its response stated the named consumer was reviewed by a Nurse practitioner on 15 and 22 November 2023, following the initial fall 01 November 2023. The Approved provider stated the consumer’s mobility and pain management were assessed during these visits, however, there is no documentation to support the review from the Nurse practitioner submitted within the Approved provider’s response. The Approved provider stated that while the consumer returned to the service 02 November 2023, following a fall sustained 01 November 2023 with a medication order for strong pain relief, this medication was for a short course duration only, and as it was determined their pain was managed with regular medication, the short course medication order was filed. I am unable to determine when or who made the decision to file the medication order. I note the short course medication order submitted as part of the Approved provider’s response did not contain a date to cease the medication and was still considered valid by staff at the service 14 days after the order was commenced. I also note, correspondence with the consumer’s medical officer following their return to the service after a second fall 03 December 2023, a request for analgesia was made. In summary, it is my decision pain management was inadequate for the named consumer following a fall sustained 03 December 2023, which required the consumer to be sent to hospital for appropriate pain relief.

The Assessment contact report states Registered staff provided the same consumer with incorrect medication on 30 and 31 October 2023. The consumer was prescribed two tablets to be taken in the evening, however the registered nurse provided the consumer with three tablets. The named consumer refused to take the additional tablet on 31 October 2023. This information was refuted by the Approved provider, noting there was no medication incident reports or file notes to evidence the concerns about additional medication was raised with management or staff. The report also states the consumer is prescribed regular pain relief to be taken four times per day, including at 2.00pm daily. The consumer and their representative stated they rarely receive the 2.00pm dose of medication on time, and this impacts on time frames between the next prescribed dose. This information was also refuted by the Approved provider in its response, which indicated the consumer receives regular pain relief three times per day and submitted medication administration records to support the administration of medication at 2pm. While I note medication administration records indicate the consumer receives medication at 2pm, I was unable to determine the type of medication, as the administration records do not record the type of medication and the medication chart submitted did not contain information to support pain relief is provided to the consumer three times per day.

For two named consumer who both have a diagnosis of Parkinson’s disease. Medication reports and feedback from one consumer evidenced time critical medication essential for the management of Parkinson’s disease was not administered as prescribed. Medications have been administered late or not within the prescribed intervals on numerous occasions. For one of the consumers with Parkinson’s disease, they were admitted to hospital on 12 November 2023 due to feeling unwell as they had not received any of their regular medication since 09 November 2023, due to a change in pharmacy providers.

In relation to time sensitive medication, the Approved provider refuted the number of instances one of the named consumers did not receive their Parkinson’s disease medication on time. The Assessment contact report records 23 occasions whereby the consumer did not receive their medications as prescribed; the Approved provider refutes this information and states between 20 November 2023 and 04 December 2023, there were 12 instances where medication was not provided within the relevant timeframes. A retrospective incident report was submitted to the Serious incident response scheme relating to the neglect of the consumer due to late medication administration. I note the medication profile for the named consumer submitted as part of the Approved provider’s response lists times for the administration of the consumer’s medication such as breakfast, lunch, dinner and supper, rather than specific times. I also noted the Approved provider stated the medication system in use at the service lists a 3.5 hour timeframe for the breakfast medication round, 2.5 hour lunchtime medication round, 2.0 hour afternoon medication round, 3.5 hour dinner medication round and a 2.5 hour supper medication round. Given the wide timeframe parameters for staff to complete medication rounds, I am not convinced the monitoring process of reviewing medication administration reports is effective in identifying deficits related to the administration of time sensitive medication. For example, for the named consumer medication administration records do not support medication provided at regular intervals but have not been identified as medication errors as the times recorded are within medication round timeframes.

The Approved provider has not refuted the named consumer did not receive their regular medication between 09 and 12 November 2023, which resulted in the consumer being transferred to hospital with chest pain, blurred vision and an increase in tremors. Email correspondence between the service and the pharmacy was submitted in the response which evidenced the named consumer experienced an increase in tremors due to missed medication. While I note staff at the service attempted to contact the consumer’s medical officer and pharmacy to obtain prescriptions, this was unsuccessful. I am also unable to determine why the Nurse practitioner was not engaged to support the continual supply of medication to the named consumer.

For a second named consumer who requires time sensitive medication to treat Parkinson’s disease, medication administration records do not support their medication was administered as prescribed. This information has not been refuted in the Approved provider’s response and the Approved provider listed actions taken to reduce the risk of time sensitive medication not being administer as prescribed. Actions taken have included a review of all consumers requiring time sensitive medication to ensure medications are packed in line with prescribed times. Alerts placed in electronic medication records relating to time sensitive medication. Education and training completed with the clinical team to ensure understanding and knowledge of required processes for time critical medication. A report is completed after each time sensitive medication round, this process is to continue for four weeks to ensure staff medication practices are embedded. The registered nurse team leader will be responsible for ensuring all time sensitive medications are being provided in a timely manner, to support a sustainable process for follow up and outside business hours accountability. The handover sheet for registered staff has been updated to include make clear any consumers requiring time sensitive medication. Despite the above actions commenced by the service, I note (as recorded in the Approved provider’s response) between 05 and 18 December 2023, three occasions the named consumer did not receive their time critical medication as prescribed.

In summary, it is my opinion time sensitive medications have not been administered as prescribed and monitoring processes are not effective in identifying medication errors, and this has had a negative impact for two consumers.

In relation to consumers with swallowing deficits, the Assessment contact report included information relating to deficits in supervision for one named consumer at risk of choking and inappropriate drinking utensil for a second named consumer at risk of choking.

For the first named consumer who experienced a choking episode 14 November 2023, it was identified that despite instructions for staff to observe the consumer every five to ten minutes during meals, there can be occasions when the consumer is not observed for 45 to 60 minutes during meals. The Approved provider in its response evidenced information the consumer prefers to have meals in their room, has capacity to make their own decisions and completed dignity of risk documentation following a refusal to be reviewed by a Speech pathologist. The consumer’s swallowing ability was assessed by clinical staff following the incident and no changes to their diet was required. Following ongoing discussions with clinical staff and the consumer relating to the risks involved with their swallowing the consumer agreed to a review by the Speech pathologist. I note through email conversations submitted in the Approved provider response that despite the service requesting the consumer be reviewed by the Speech pathologist on 21 November 2023, due to a communication error the consumer was not reviewed until 12 December 2023. Diet modifications were made following the Speech pathology review and current information was noted in care documentation submitted by the Approved provider.

For a second named consumer at risk of choking, it was observed they were not in possession of a recommended drinking utensil to reduce the risk of choking. The consumer had a choking episode 27 October 2023, and prior to this episode a discussion had been held with the consumer’s representative who suggested the use of a two-handled cup. Following feedback during the Assessment contact visit, the following activities were implemented, a report to be attached to the tea trolley was updated to include the use of a two-handled cup, all dietary reports were reviewed to ensure up to date information was recorded which was reflective of service requirements and a review of staff allocation to ensure regular staff were available to disseminate utensils and specialised requirements. While most information submitted by the Approved provider contained information relating to the specialised equipment and the need for the consumer to receive thickened fluids, I note a list of drink requirements printed 21 December 2023, contains directives the consumer may have thin fluid. I do not have evidence to support this incorrect information led to the consumer being provided fluid which was not the correct consistency.

The Assessment contact report contained information relating to ineffective monitoring and recording systems in relation to time critical medication incidents. The Approved provider has refuted this information and stated all incidents were captured as part of the incident management processes at the time the incidents were made known. Incidents that were not known prior to the Assessment contact visit have been acknowledged and made evident in the Approved provider response with associated documentation. A plan for continuous improvement has been developed to address deficits raised within the Assessment contact report. The Approved provider had previously identified the shortfalls of some of the reporting functions of the electronic care system and is currently implementing a project to review alternate providers and upgrade systems in 2024.

While I acknowledge the actions taken and planned by the Approved provide to address deficits identified in the Assessment contact report, it is my decision at the time of the Assessment contact three consumers were not receiving their time sensitive or pain relief medication safely, correctly or in a timely manner. Therefore, the high impact risk of medication administration was not effectively managed. For a consumer at risk of choking, supervision at mealtimes was not consistently occurring as directed to reduce the risk of choking episodes.

Based on this information, this Requirement is Not 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.**

Consumers were confident staff knew their needs and could identify changes to their condition and knew how to respond. The service demonstrated changes in a consumer’s health and well-being were recognised and responded to in a timely way. Care documentation identified staff recognised, reported, and responded to changes in consumers’ condition in a timely manner. Registered staff advised actions taken included assessment of the consumer, discussion with the consumer and representative, referral to the medical officer or other allied health professionals, and transfer to hospital where necessary. Care staff appropriately escalated to registered staff where they had concerns about a consumer’s condition.

Care staff described how they escalated changes in consumers’ condition to registered staff and provided examples of when they would escalate, such as if the consumer was not eating, or very tired. Registered staff described how they assessed deterioration and immediately implemented monitoring, charting, and relevant referrals. Management conducted two imitation critical incident drills to evaluate staff response, and both were successful. Clinical management and staff confirmed, the service provided education for staff to identify deterioration and the process for escalation. The service had policies and procedures to guide staff in relation to identifying and responding to consumer deterioration.

Based on this information, 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. | Compliant |

Findings

The Assessment contact report contained information from four named consumers that a lack of adequate staffing has led to negative care outcomes for them, including delays in toileting, medication administration and care provision. The Approved provider in its response provided information the named consumers met with management to address their concerns and provide feedback. Call bell response times were reviewed by the Approved provider for the four named consumers who provided negative feedback regarding staffing, the call bell response review did not identify systemic lengthy delays in call bell response times. Closed circuit television footage was also reviewed to support timely provision of care by staff to the four named consumers.

Care and registered staff provided feedback there was insufficient staff to support safe and quality care provision. Registered staff stated allocated tasks are at times handed over to the oncoming shift or they extend their shift to complete their tasks. A registered staff member stated consumers who require assistance or supervision during mealtimes were often left unattended due to staffing constraints. Care staff provided feedback the memory support unit is often short staffed, and when they are short staffed wound care and showers are often not completed as planned. Care staff stated kitchen staff can be required to assist with personal cares, as there is a lack of care staff. Management advised the service was heavily reliant on agency staff members, particularly for registered staff.

The Approved provider in its response acknowledged the difficulties in recruiting and retaining experienced staff, and stated ongoing activities are implemented daily to ensure ongoing recruitment and coverage. Temporary or agency staff are contracted and utilised to ensure roster coverage. The Approved provider evidenced all shifts in the two weeks prior to the Assessment contact were filled with either regular or temporary staff. In the week prior to the Approved provider submitting their response six new staff members commenced, including five care staff members. The Approved provider clarified there is not a memory support unit onsite, rather some consumers may wear security bracelets which lock doors if they attempt to leave the area.

It is my decision there is little evidence to support a lack of staffing impacting on the delivery of care for consumers at the service, and the Approved provider is proactive in ensuring staff are recruited and trained to deliver adequate care and services.

Therefore, 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)