Performance

Report

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| Name of service: | Piper House |
| Service address: | 4 Lindsay Evans Place DAPTO NSW 2530 |
| Commission ID: | 2669 |
| Approved provider: | Anglican Community Services |
| Activity type: | Assessment Contact - Site |
| Activity date: | 13 April 2023 |
| Performance report date: | 10 May 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 Piper House (**the service**) has been prepared by G Cherry, 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 3 May 2023
* Performance Report dated 13 April 2022

# 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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of seven specific requirements have been assessed and found compliant.

Requirement 3(3)(a)

A decision was made on 13 April 2022 that the service was non-compliant in requirement 3(3)(a) after a site assessment conducted 14-16 February 2022. The service was unable to demonstrate an effective system to ensure safe and effective best practice care tailored to consumers’ needs.

At an assessment contact visit conducted on 13 April 2023 the assessment team bought forward evidence within the service’s Plan for Continuous Improvement (PCI) and via discussions with management the following actions have occurred in relation to previously ineffective restrictive practices not tailored to consumer’s needs.

An action relating to restrictive practices was created on 15 February 2023 (completion due 30 June 2023).

Planned actions include:

* To develop, monitor and updated an onsite psychotropic medication register.
* Ensure all restrictive practices are documented in consumer’s care plan.
* Ensure consumers being administered psychotropic medication have a behaviour support plan (BSP).
* Ensure alternative strategies are documented and utilised prior to restrictive practice use.
* Ensure consistency in all documentation. Ensure new strategies are communicated to staff and updated in care plans/BSPs when consumer’s experience changed behaviours.
* Educate registered nurses on importance of monitoring and early identification of side effects for consumers being administered psychotropic medication.
* Communicate behaviour charting and interventions to care team by way of meetings/handover discussions and evaluate for effectiveness.
* The organisation’s dementia clinical nurse consultant (CNC) has commenced education relating to BSPs. Registered nurses attended workshops in January and February 2023. Further education is planned.

Via review of documentation the assessment team bought forward evidence 1 consumer (who entered the service four months ago) prescribed with psychotropic medication did not have a BSP to guide staff in care delivery. Two other consumers BSP’s did not contain details of prescribed psychotropic medications. Management immediately updated BSP’s.

In their response the approved provider contends appropriate documentation is in now place relating to the psychotropic medication deemed as restrictive practices including current BSPs reviewed by the organisational dementia nurse consultant. In addition, a clinical pharmacist has been engaged to conduct a medication review for 1 named consumer. While they contend availability of relevant information in alternate documentation, evidence of updated BSP’s was supplied. In addition, the approved provider demonstrated education provided to registered nurses relating to restrictive practices and development of BSP documentation.

In relation to wound management and instances of consumers not receiving skin management care aligned with best practice. The continuous improvement plan and discussion with management detail the following actions.

* Staff education relating to skin integrity.
* Registered nurse education on pressure injury classification.
* Consumer repositioning schedules to continue.
* Ensure appropriate pressure relieving devices are in place.

The service’s PCI and discussions with management note the following actions have occurred in relation to wound management. An improvement action was created on 14 January 2023 (completion due 30 June 2023).

Planned actions include:

* Medical officer to prepare referral letters to wound CNC.
* Raise awareness and train registered nurses relating to importance of using best practice methods during assessment.
* Contact consultant to review current dressings and recommend wound dressings according to best practice.
* Create wound management folder.
* Ensure that wound assessment is continuously completed.
* Ensure consistency of wound photography (including measurements). Additional cameras for each wing (4) were purchased during January 2023.
* Monitoring pain management - ensure administration of analgesia prior to attending wound dressings.
* Organise/deliver training for registered nurses and care staff.

Via review of documentation the assessment team noted overall most wound documentation include wound photography, however some photographs did not include tape measurements to enable monitoring/identification of changes to wound condition. The assessment team noted inconsistent recording of preventative pressure injury care for one consumer although observed appropriate preventative equipment in situ. Immediate education was provided to care staff relating to importance of documenting repositioning times. In addition, management committed to conducting a review of all consumers documentation to ensure appropriate file notations are in place.

In their response the approved provider acknowledge pressure area care not recorded for one consumer however note subsequent wound specialist review has been completed. As a method to enable staff to record care delivery at the bedside they ordered mobile devices (awaiting delivery).

In coming to a decision on compliance I have given weight to the immediacy of management’s actions to deficits bought forward by the assessment team (while on site) and considered the approved provider’s comprehensive actions, including consultation with named consumers/representatives to ascertain satisfaction and health specialist involvement.

I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b)

A decision was made on 13 April 2022 that the service was non-compliant in requirement 3(3)(b) after a site assessment conducted 14-16 February 2022. The service was unable to demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer, in particular relating to complex clinical needs and safe medication storage.

At an assessment contact visit conducted on 13 April 2023 the assessment team bought forward evidence within the service’s PCI and via discussions with management the following actions have occurred in relation to previous findings of non-compliance.

* The current site management team (new to the service) identified gaps in care planning documentation and reviews. Monitoring processes, plus recent appointment of 2 additional registered nurses, has resulted in care plan reviews being conducted, with a planned completion date of end April 2023.
* Weekly meetings (plus monitoring processes) are utilised to oversee completion and management note 6 of 17 comprehensive care plans are outstanding however an interim care plan is in place for these consumers. Management advise the current electronic care system incorporates clinical assessments but does not automatically create a care plan.
* Individual education has been provided by the clinical nurse educator to registered nurses when documentation deficits have been identified.
* A weekly report is to be introduced to monitor changes to clinical needs of individual consumers. Key topics (including high impact/high prevalence risks) such as falls, unplanned weight loss, palliative care or other clinical changes will be documented within the report.

Sampled consumers express satisfaction with clinical care provision, including timely response to requests for assistance. A review of documentation detailing consumer’s vital signs note monitoring of oxygen saturation levels and the assessment team observed medication trolleys appropriately attended.

Documentation review of consumers files demonstrate recording of fluid intake is occurring for one consumer, however noted conflicting details relating to indwelling catheter (IDC) for one consumer. Management review resulted in identifying an IDC not currently required. As a result, management actioned an improvement activity to manually monitor suprapubic (SPC) and IDC requirements. They acknowledge the electronic care system not adequately recording/identifying changes. While review of one consumer’s file demonstrate appropriate management of blood glucose levels (BGL) and involvement of palliative care team, another consumer’s file detailed inconsistent monitoring/recording of BGL’s and/or subsequent actions when recorded levels exceed medical officer parameters.

Management provided immediate education to registered nurses in relation to BGL monitoring expectations and committed to undertaking a review of all consumer’s files.

In their response the approved provider acknowledge the service experienced a four-month period without management overview and support however both a Residential and Care Manager have now been appointed. They cite as a result; concrete actions are being executed via a schedule and PCI to ensure necessary systems are embedded and effectively implemented within governance frameworks. They provided evidence care plans (including complex cares) have been reviewed/updated by clinical staff and monitoring systems implemented to ensure continuous review. In addition, they refute BGL monitoring documentation was not updated and supplied supporting documentation to evidence recording and appropriate actions occurred for two sampled consumers.

In coming to a decision on compliance I have given weight to the immediacy of management’s actions to deficits bought forward by the assessment team (while on site) and provision of evidence to support effective systems in managing high impact/prevalence risks associated with the care of each consumer.

I find requirement 3(3)(b) 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)