Performance

Report

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| Name: | Presbyterian Aged Care - Thornleigh |
| Commission ID: | 0530 |
| Address: | 3 Hillmont Avenue, THORNLEIGH, New South Wales, 2120 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 3 June 2024 to 4 June 2024 |
| Performance report date: | 10 July 2024 |
| Service included in this assessment: | Provider: 479 The Presbyterian Church (New South Wales) Property Trust  Service: 543 Presbyterian Aged Care - Thornleigh |

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 Presbyterian Aged Care - Thornleigh (**the service**) has been prepared by J Durston, 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 on 21 June 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements were assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not 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)(a) - the approved provider is to review its medication incident management process to ensure delayed supply of medications critical to the health, safety and wellbeing of consumers by nominated representatives are identified as incidents to be investigated and risks to be escalated for effective clinical management and risk mitigation.
* Requirement 8(3)(d) - the approved provider is to review its incident and risk governance systems and processes to ensure high impact high prevalence risks associated with behaviour support and diabetic management are identified, communicated, addressed and mitigated at the operational level and through the strategic intervention of the governing body.

# 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. | Not Compliant |

Findings

The service was previously found non-compliant in Requirement 3(3)(a) following a Site Audit conducted 7 June 2023 to 9 June 2023. Following the Assessment Contact conducted on 3 June 2024 to 4 June 2024 the Assessment Team recommended during the Assessment Contact the Assessment Team recommended that while the service is managing certain areas of clinical care effectively, such as weight loss, catheters, falls and wound management, they did not demonstrate effective diabetes management and behaviour support. Further, the Assessment Team reported management acknowledged there were deficits in incident identification, analysis and reporting that were not consistent with best practice.

The Assessment Team found that overall consumers and representatives provided positive feedback in relation to personal and clinical care. However, there was ineffective clinical oversight including incident identification, analysis and clinical risk mitigation for one consumer living with mixed dementia and unstable type 2 diabetes. The consumers did not receive their prescribed regular insulin and their blood glucose levels (BGLs) were not effectively monitored and checked prior to administering fast acting insulin. The consumer’s BGL monitoring chart showed that from 4 April 2024 to 21 May their BGLs were taken on six occasions, but during that period the consumer was administered PRN fast acting insulin on ten occasions. Hence, four of the PRN insulin doses were administered without prior BGL testing. In addition, the care plan did not include strategies to be used when the consumer displayed behaviours of concern towards staff while refusing to allow them to test their BGLs.

Documentation indicated that clinical staff had not been administering the consumer’s daily regular insulin prescribed by the geriatrician because the representative had not provided the medication to the service as arranged. Care documentation showed the medical officer explained to the representative in a case conference on 18 April 2024 that the consumer consistently experienced high BGLs throughout the week because they were not receiving long-acting insulin. The service advised the Assessment Team that lack of medication stock was part of the service’s incident reporting policy. But the Assessment Team found incident reports were not completed to effectively mitigate missed insulin doses and BGL testing for the consumer. Management acknowledged inconsistencies in incident report completion that did not ensure care was tailored to meet the needs of the consumer and ultimately their health, safety and wellbeing.

The Assessment Team reported when this was raised with management the service’s quality team committed to a full review of the consumer’s care and said they would report the medication incidents through the Serious Incident Response Scheme (SIRS) to the Commission as incidents of neglect. Management confirmed and advised a full review involving the organisation’s clinical advisor would occur and the learnings will be utilised at an organisational level.

In their response to the Assessment Team report the provider disputed the following findings by the Assessment Team in relation to this requirement.

BGL readings

The provider disputed the finding that BGL readings were not carried out before administering short acting insulin to the consumer. The provider supplied copies of the consumer’s vital observation charts from the electronic care management system (ECMS). The provider noted the Assessment Team would not have been aware that BGL recordings in the ECMS require a numerical value so that when the BGL was high staff documented it in the narrative section of the vitals observations chart as ‘hi’.

The provider supplied further evidence of BGL testing prior to insulin administration in medication charts. However, on reviewing both charts I note there was inconsistent recording of BGL readings. In the vital observation chart, sometimes BGLs were recorded numerically in the BGL numerical reading column, and at other times they were recorded as ‘hi’ in the narrative column. The medication chart dated 4 April to 21 May 2024 showed that BGL readings were again recorded inconsistently, as above.

Having considered the evidence, I acknowledge the records indicate BGLs appear to have been taken prior to insulin administration. However, I am not satisfied the lack of consistency and specificity of BGL values recorded demonstrates safe and effective tracking, management and prevention of the potential risks to the consumer’s health caused by long term, unstable and significantly elevated BGLs. Particularly in the context of the consumer’s reluctance to be tested.

Incident and SIRS reporting

The provider disputed the finding that medication incident reports and SIRS reports should have been processed on the occasions the consumer did not receive their prescribed regular long-acting insulin dose between 14 May 2024 and 3 June 2024 when the representative did not supply the prescribed insulin. The provider responded that the service did not attend medication incident forms for each time the insulin was omitted as they had clear verbal instructions from the geriatrician not to commence treatments until continuous blood sugar monitoring device was available, and written documentation from the geriatrician not to commence insulin until the consumer’s nominated representative supplied the medication. The provider concluded there were no medication omissions as the service was awaiting supply of the essential equipment before treatment commenced. The lack of supply was not escalated to the Quality Team or the chair of Presbyterian Aged Care or director of residential care for further investigation.

In weighing up the evidence, I understand the service advised the Assessment Team that lack of medication stock was part of medication incident reporting policy. I acknowledge the provider’s evidence that the geriatrician directed that administration of regular insulin should not commence until supplied by the representative. I acknowledge the service’s documented attempts to contact the representative requesting delivery of the insulin. However, the Assessment Team found the medication was charted, the insulin was not supplied for an extended period (more than two weeks) after it was prescribed, while the consumer continued to experience consistently high BGL readings placing their health safety and wellbeing at significant risk. I consider the risk escalation should have occurred at the point of care regardless of whether it was instigated as a medication incident or another incident type. The non-supply of prescribed insulin to the service (by the representative) for two weeks resulting in the lack of stock available exposed the consumer to high impact high prevalence risks to their health and wellbeing.

I conclude from the evidence that the lack of medication or other incident documentation, did not ensure this risk was escalated to the facility manager, the quality team and the Board to ensure the organisation could effectively analyse and work towards mitigating high impact, high prevalence risks for this consumer and other consumers in the future. Further, I consider that given the likelihood the consumer would experience high BGLs in the absence of the prescribed regular insulin, the inconsistent documentation of BGL measures reflected clinical monitoring that was not best practice.

In their response the provider outlined the actions taken since the Assessment Contact to more effectively manage the consumer’s diabetes, including:

* After the clinical review undertaken by the service’s Quality Team, the service made a referral to the Dementia Support Australia (DSA) on 4 June 2024 and requested assistance with the consumer’s diabetic management. The provider supplied excerpts from the DSA’s response. In summary DSA advised they would not be able to provide recommendations regarding diabetic management and recommended the service should involve a diabetic consultant, and follow-up more appropriate services for diabetic management. DSA closed the referral. The provider noted in their response that despite the recommended behaviour support strategies being used, the consumer continues to decline to have their BGLs attended except when the representative visits, preventing the administration of regular insulin required to stabilise the consumer’s BGLs.
* The provider acknowledged the consumer’s BSP had a general statement regarding encouragement needed when the consumer declines BGLs. The service updated the consumer’s diabetic management plan and the BSP on 6 June 2024 following reviews by the dietician and DSA. The BSP contains strategies to be used when the consumer declines BGLs, including suggestions from the representative. The provider noted the representative’s suggestions were only shared with the service when the assessors interviewed the representative during the Assessment Contact. The dietician made recommendations on fluid intake to assist with stabilising the consumers’ BGLs. The behaviour support plan was not supplied as evidence by the provider.
* The Quality Team has undertaken a root cause analysis investigation into the consumer’s care needs. Recommendations from the investigation will be discussed at the next Quality and Clinical Care meeting and therefore shared with senior management Care Mangers, and Quality Team. The results of the root cause analysis were not supplied as evidence by the provider.
* In their response the provider noted that based on the GP’s advice and letter dated 13 June 2024 they have raised the possibility with the representative of considering palliative care for the consumer the letter recommended consideration of palliative care for the consumer due to the service being unable to administer insulin, the patient’s age and discussion from the last case conference. A progress note dated 14 June 2024 stated the geriatrician verbally advised they will cease insulin for the consumer after discussion with the representative and the care manager updated the geriatrician on application for continuous glucose monitoring device and supporting letter required from the geriatrician.
* According to the provider’s response, the service is in the process of making and application to NDSS for a continuous blood sugar monitoring device, to replace the finger prick BGL monitoring for the consumer.

I commend the actions taken by the service both during and after the Assessment Contact to address the issues identified by the Assessment Team and to improve the safety and effectiveness of the consumer’s diabetes care and to reduce the risk of health complications associated with the consumer’s continuously high BGLs. However, I consider the evidence brought forward in both the provider’s response and the Assessment Team report confirmed the consumer’s resistance to diabetes care, in particular blood glucose monitoring, has existed since 2021 when they were first diagnosed with type 2 diabetes and lived with moderate dementia. Further, two dignity of risk forms supplied in the provider’s response showed the consumer’s resistance to diabetic care co-existed with a broader behavioural pattern of resistance to care, which was not effectively managed either separately or as a whole by the service.

The dignity of risk form dated 4 July 2023 and updated 2 March 2024 identified the consumer’s resistive behaviour towards care delivery when approached by staff to assist with personal hygiene care, toileting and continence care. Although the document identified the risks of care resistance such as falls, poor hygiene and infection, I consider the recorded behavioural support strategies to be mainly generic with the possible exception of the use of communication cards and assistance from Chinese speaking staff. The provider did not supply additional evidence of timely referral to specialised behavioural and/or diabetic management services to assist with the consumer’s broader care resistant behaviours and/or refusal of diabetes care since the consumer’s hospitalisation for diabetes management in 2021, except for the referral to DSA during the Assessment Contact requesting assistance with a specific and limited focus on managing behavioural issues in relation to resistance to BGL testing and diabetic care.

On the balance of evidence provided, I consider that although the service is managing certain areas of clinical care effectively, I do not consider the service provided safe and effective clinical care that was best practice in relation to diabetes and behaviour management.

Based on the information summarised above, I find the service non-compliant in Requirement 3(3)(a).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was previously found non-compliant in Requirements 6(3)(a) and 6(3)(d) following a Site Audit conducted 7 June 2023 to 9 June 2023. Following the Assessment Contact conducted on 3 June 2024 to 4 June 2024 the Assessment Team recommended the service met both requirements.

Requirement 6(3)(a)

The Assessment Team found the service encourages and supports consumers, their family, friends and carers to provide feedback and make complaints. Some consumers confirmed this in their feedback. Other consumers and representatives advised the new facility manager is more responsive to receiving feedback leading to improved support and encouragement to raise concerns, feedback and complaints. The service has internal and external feedback and complaints processes, such as consumer feedback surveys consumer and representative meetings, emails. Staff were able to describe they ways they can assist consumers to provide feedback.

Requirement 6(3)(d)

The Assessment Team found the service demonstrated it uses a feedback and complaints register to track and review feedback ad complaints to inform quality improvement of care and services. Some consumers and representatives confirmed care and service improvements were made following feedback and complaints. These improvements including consumer satisfaction were documented in the minutes of consumer and representative meetings. The minutes noted the service increased laundry staff hours in response to a complaint on delayed return of clothing, and the menu was changed, including a reduction in servings of peas in response to a representative’s concern about the lack of variety of green vegetables provided to consumers.

Based on the information summarised above, I find the service compliant in Requirements 6(3)(a) and 6(3)(d).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was previously found non-compliant in Requirements 7(3)(c), 7(3)(d) and 7(3)(e) following a Site Audit conducted 7 June 2023 to 9 June 2023. Following the Assessment Contact conducted on 3 June 2024 to 4 June 2024, the Assessment Team recommended the service meet the three requirements.

Requirement 7(3)(c)

The Assessment Team found the service demonstrated it has a competent workforce and staff have the qualifications and knowledge to effectively perform their roles. Most consumers and representatives advised staff were competent in their roles. Two consumer representatives indicated there were some deficiencies in relation to staff communication with consumers living with dementia, while other consumers and representatives expressed their satisfaction with staff knowledge and ability to engage with consumers living with dementia. The service manager confirmed staff completed Training with Dementia Support Australia in 2023, committed to reviewing the two consumers mentioned and committed to providing further training to staff on effective communication and interaction with consumers living with dementia. The organisation has documented core competencies/capabilities for each role and evidence was provided that staff competency assessments were up to date and competencies are reattended following incidents such as manual handling.

Requirement 7(3)(d)

The Assessment Team found the service demonstrated it has effective processes for recruitment, orientation and training that equip staff to deliver the outcomes required by the quality standards. This was supported by review of staff training completion rates, feedback from consumers and representatives, management and staff. Training records showed the mandatory training completions for 2024 were up to date and all staff completed mandatory training in 2023. Management advised registered nursing staff complete face-to-face scenario-based training annually that focuses on the Serious Incident Response Scheme (SIRS) and critical incidents, and additional training is provided when incidents occur or when requested by staff.

Requirement 7(3)(e)

The Assessment Team found the service demonstrated there is regular assessment monitoring and review of staff performance. Staff records showed most staff performance appraisals were completed in 2023 and approximately 50% have been completed in 2024. Management advised the service monitors and reviews staff performance through incidents, consumer feedback and review of progress notes, with 6-monthly performance appraisals upon commencement, and annually thereafter.

Based on the information summarised above, I find the service compliant in Requirements 7(3)(c), 7(3)(d) and 7(3)(e).

# 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. | Not Compliant |

Findings

The service was previously found non-compliant in Requirements 8(3)(c), and 8(3)(d) following a Site Audit conducted 7 June to 9 June 2023. Following the Assessment Contact conducted on 3 June 2024 to 4 June 2024, the Assessment Team recommended the service met Requirement 8(3)(c) but not Requirement 8(3)(d).

**Findings of non-compliance**

Requirement 8(3)(d)

The Assessment Team found the organisation did not demonstrate the use of effective risk and incident management policies, systems and practices to manage and prevent high impact high prevalence risks, abuse and neglect and dignity of risk for all consumers. The risk management systems were not effective in identifying, overseeing and managing the potential high impact, high prevalence risks for one consumer living with type 2 diabetes and diagnosed with mixed dementia. Ineffective risk management at the point of care for this consumer was considered in Requirement 3(3)(a).

The consumer outcome summary in the Assessment Team Report noted the dignity risk documentation completed on 17 April 2024 stated that due to the consumer’s cognitive impairment and their choice being respected, BGL and PRN insulin was to be administered when their representative visited as the consumer often refused BGL readings, only allowing them to occur when their representative was present. However, the Assessment Team found dignity of risk documentation did not outline the actual and potential risks for the consumer if their diabetes is not effectively managed due to non-receipt of insulin, nor the risks of insulin administration without BGL monitoring.

The Assessment Team found the consumer’s care highlighted deficits in the organisation’s risk governance at both the strategic and operational levels. The organisation’s risk management systems were dependent on identification of risk at service level, which did not occur. The lack of medication incident documentation did not ensure this risk was escalated to the facility manager, the quality team or the governing body so that the organisation could analyse causal factors and mitigate similar high impact high prevalence risks for this consumer and others both now and into the future.

The consumer is diagnosed with mixed dementia and was assessed by the geriatrician to lack the capacity to make decisions for themselves The Assessment Team found the consumer did not have an authorised substitute decision maker in place at the time of the Assessment Contact to make **health care and/or medical treatment decisions to minimise risks to the consumer’s health, safety and wellbeing.**

In their response to the Assessment Team report the provider disputed the following findings by the Assessment Team in relation to this requirement.

Risk governance

The provider disputed the Assessment Team’s finding that the organisation did not demonstrate the use of effective risk and incident management policies, systems and practices to manage and prevent high impact high prevalence risks to consumers. In their response, the provider stated the organisation has a ‘robust’ organisational risk management system in place to oversee high impact high prevalence risks. The provider described how incidents and risks at service level are escalated through the organisation’s incident and risk management systems and are documented in the facility manager’s monthly report received by the Chair of Presbyterian Aged Care, the director of residential care and the quality team. The provider advised quality audits are completed regularly as part of the organisation’s risk management system. The provider stated that consistent with the service’s medication incident management policy, medication incident and SIRS reports were not completed when the consumer’s prescribed medication was not supplied by the representative as directed by the geriatrician. This was considered in Requirement 3(3)(a).

Dignity of risk

The provider disputed the Assessment Team’s finding that the dignity of risk form completed on 17 April 2024 did not contain the actual and potential risks for the consumer if their diabetes is not effectively managed. The provider noted the risks were also discussed in the family case conference with GP on 18 April 2024. The provider supplied a dignity of risk form that included the risks associated with the consumer’s ‘refusal to take weekly BGLs, insulin and blood tests in accordance with the GP’s instructions and medication chart.’ The risk level was rated as extreme and potential risks were recorded as heart disease, stroke, nerve and kidney damage, vision loss, seizures, loss of consciousness and death.

In their response the provider outlined the actions taken since the Assessment Contact to more effectively manage the consumer’s diabetes

* The provider advised they have requested the consumer’s nominated representative to apply for Guardianship given the consumer’s dementia diagnosis and cognitive impairment. However, to date, the representative has not yet done so. The matter was escalated to the Chair of Presbyterian Aged Care and the provider has commenced a Guardianship application on behalf of the representative due to ongoing difficulty sourcing medications and their lack of clinical understanding of the consumer’s care.

On balance, when I consider all the information before me, I am not satisfied that the organisation’s incident and risk governance is sufficiently robust. I acknowledge the service has a multidisciplinary, multi -level risk management process and system in place. However, I put weight on the evidence presented in the Assessment Team report that during the Assessment Contact the care manager indicated she was aware that regular insulin was not being administered to the consumer as prescribed, but the facility manager was not. I consider this indicates a significant disconnect within operational and strategic risk governance.

I am not convinced that without review of the consumer’s diabetes management during the Assessment Contact, that the governing body would have been informed and positioned to consider and provide direction on organisational strategies to mitigate high impact high prevalence risks associated with diabetes management for this consumer and other consumers in similar situations. Nor am I satisfied that the governing body would have been alerted to critically review potential gaps in the organisation’s approach to medication incident management and reporting, particularly in relation to identifying and managing the risks of lengthy delays in supply of prescribed medication critical to the health and safety of consumers, by nominated representatives.

Based on the information summarised above, I find the service non-compliant in Requirement 8(3)(d).

**Compliant Requirements**

Requirement 8(3)(c)

The Assessment Team found the service was able to demonstrate it has effective governance systems in place in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The service has an electronic care management system with incident management functionality, an electronic feedback, complaints and continuous improvement system. There were deficits in the risk management information systems, however this was considered in Requirement 8(3)(d).

The organisation has a system of audits and internal monitoring, feedback systems, surveys and consumer forums to identify opportunities for care and service improvements. The organisation has a quality team that oversees continuous improvement at the service level and reports to the Board for governance oversight.

There are financial delegations assigned to ensure expenditures are within budget and there are processes in place to purchase out of budget items when required.

The service’s strategic workforce plan and its baseline roster framework ensures there are sufficiently skilled and qualified staff to provide safe, and effective care to consumers.

The organisation’s management and meeting systems communicate changes to regulatory/legislative requirements and policies throughout the organisation.

Complaints and feedback are recorded in the service complaints register. The Chair of Presbyterian Aged Care and quality team advised complaints are risk rated and reported to the board as required.

Based on the information summarised above, I find the service compliant in Requirement 8(3)(c).

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)