Performance

Report

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| Name: | Victoria Park Nursing Home |
| Commission ID: | 7862 |
| Address: | 1 Croesus Street, KALGOORLIE, Western Australia, 6430 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 27 August 2024 |
| Performance report date: | 25 September 2024 |
| Service included in this assessment: | Provider: 896 Southern Cross Care (WA) Inc  Service: 4869 Victoria Park Nursing Home |

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 Victoria Park Nursing Home (**the service**) has been prepared by Jemma 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 (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 17 September 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **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.

* Ensure assessment and planning processes include risks and mitigation strategies to inform the delivery of safe and effective care and services.
* Ensure processes are in place to support staff to effectively manage the high impact and high prevalence risks associated with the care of each consumer.
* Ensure risk management systems are in place to effectively monitor and manage high-impact and high-prevalence risks.

# 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. | Not Compliant |

Findings

The assessment team recommended Requirement (3)(a) not met, as they were not satisfied assessment and planning processes enable staff to deliver safe and effective care and services in relation to changed behaviours. The assessment team’s report included the following evidence relevant to my finding:

* Consumer A entered the service in May 2023 from the co-located service. Care documentation showed patterns of changed behaviour had been identified with strategies implemented; however, staff feedback and care documentation showed strategies were ineffective. Management could not show evidence of ongoing assessment and planning being undertaken in relation to the consumer’s escalation of behaviour.
  + Care documentation showed the consumer’s behaviour was impacting on the management of their diabetes, and compliance with a fluid restriction.
  + Management described, and documentation confirmed, a new behaviour support plan had been developed to support the consumer; however, had not been implemented at the time of the assessment.
* Consumer B entered the service in June 2024 from the co-located service. Assessment and planning processes prior to June 2024 did not guide staff in delivering safe and effective care and services, resulting in unplanned hospital admissions and escalating behaviours. The consumer has not recorded any incidents or unplanned admissions since admission to this Service.
* Management and staff described assessment and planning processes which include assessment of risks using validated assessment tools to inform the delivery of safe and effective care.
* Management and staff described risk assessments being undertaken for consumers with changed behaviours when being assisted with toileting, and consumers who are unable to mobilise and are at risk of pressure injuries. Care documentation confirmed risk assessments are undertaken.

The provider did not agree with the assessment team’s recommendation. Their response included the following evidence relevant to my finding:

* Additional information for consumer A included assessments undertaken in relation to risks:
  + Nutrition and hydration assessments dated June, July and August 2024, include assessment of risks in relation to prescribed fluid restrictions, and preference to eat outside speech pathologist recommendations. However, assessments did not include mitigation strategies to minimise the identified risks.
* For consumer B additional documentation provided included behaviour charting and assessments undertaken in December 2023. Ongoing behaviour charting was provided for August 2024 which demonstrated recording of behaviours.

While I acknowledge the providers response, I find the Service does not undertake assessment and planning processes, including the assessment of risk, to inform the delivery of safe and effective care and services. In coming to my finding, I have considered the information provided, and acknowledge the completion of some risk assessments being undertaken in relation to the named consumers. However, within the additional information provided, I find that when risk assessments have been undertaken, mitigation strategies have not been implemented to mitigate the risks, and therefore does not inform the delivery of safe and effective care and services. Additionally, I have not been provided evidence of reassessment processes being undertaken in relation to Consumer B since entering the service from the co-located service.

I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers not 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 |

Findings

The assessment team recommended Requirement (3)(b) not met as they were not satisfied consumers high impact and high prevalence risks were being effectively managed, particularly in relation to changed behaviours. The assessment team’s report included the following evidence relevant to my finding:

* Two consumers with changed behaviours did not have effective behaviour support strategies implemented in a timely manner, resulting in escalating behaviours and unplanned hospital transfers.
* Staff described, and documentation confirmed, the current strategies in place to support consumer A and said they were ineffective, resulting in verbal and physical aggression towards staff. At the assessment contact, staff described, and a behaviour assessment dated November 2022 included, generic strategies and interventions which were reported as ineffective, with staff describing they were not able to effectively manage the changed behaviours. Management acknowledged care documentation from October 2022 to May 2024 did not accurately reflect the needs of consumer A.
* Prior to entering the service on 12 June 2024 from the co-located service, consumer B recorded multiple hospital transfers due to changed behaviours. Since entry into the service, no further incidents were reported. Care documentation and staff confirmed a review was undertaken by Dementia Support Australia (DSA) in June 2024, with strategies implemented to support Consumer B. Staff and training records confirmed education and training had been undertaken in behaviour management and Parkinson’s disease and staff confirmed the current strategies are effective in managing consumer B’s changed behaviours.

The provider did not agree with the assessment team’s recommendation and provided the following information relevant to my finding:

* An updated behaviour support plan (BSP) for consumer A, which was informed by mental health and dementia consultants in June 2024 and was available to staff at the time of the assessment contact. An additional BSP dated 21 August 2024 was also provided and included additional strategies to support consumer A.
* Training records to demonstrate training on Parkinson’s disease and behaviour support had been delivered in April 2024.
* Care documentation for consumer B show collaboration a mental health service and geriatrician to develop a care plan with interventions and strategies for changed behaviours in April and June 2024. Additional behaviour charting with corresponding assessment showed ongoing monitoring of behaviours.

While I acknowledge the providers response, I find the service does not have processes in place to effectively manage the high-impact or high-prevalence risks associated with the care of each consumer. In coming to my finding, I have placed weight staff comments within the assessment teams report regarding the strategies in place to support the changed behaviours of consumer A. Staff provided feedback to the assessment team stating the strategies for supporting changed behaviours for consumer A were ineffective and they did not know how to support the behaviours displayed. While I acknowledge the implementation of an updated BSP for consumer A, the strategies outlined will require time to be fully implemented and evaluated for effectiveness. I have also considered the intent of this Requirement in coming to my finding, where the Service is required to manage the risks related to personal and clinical care of each individual consumer.

I find for consumer A, the service has not demonstrated effective management of the high impact risks related to their care, and therefore, I find Requirement (3)(b) in Standard 3 Personal care and clinical care not compliant.

# 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. | Not Compliant |

Findings

The assessment team recommended Requirement (3)(d) as not met as they were not satisfied the risk management system is effective in recording and analysing incidents through the incident management system or supporting staff in managing the high impact and high prevalence risks associated with consumers care, specifically in relation to changed behaviours. The assessment teams report included the following evidence relevant to my finding:

* For consumer A, support was not provided by staff to manage their changed behaviours, nor were specialised support services been engaged.
* The incident management system did not record all incidents of verbal aggression towards staff, ensuring trends were identified and analysed. Management acknowledged verbal aggression was not consistently documented as staff did not consistently identify verbal aggression as a behaviour.
* The organisation has recently implemented a positive behaviour committee to monitor, trend and analyse occupational violence issues.

The provider did not agree with the assessment team’s report and provided the following information relevant to my finding:

* The provider acknowledged staff were not consistently recording behaviours on consumer behaviour charts as they had perceived the consumer’s behaviours as normal. Education and training had been provided in April, May and June 2024.
* Weekly multi-disciplinary team meetings commenced on 6 September 2024 where incidents and concerns from the previous week are escalated and discussed.
* All staff meeting minutes dated February 2024, April 2024, and May 2024 include discussions on consumers with changed behaviours, and health or clinical issues of concern. There were no minutes provided for July 2024.
* Meeting minutes from positive behaviour support management committee meeting dated 22 May 2024 showed training in de-escalation was discussed and implemented, and consumer’ with challenging behaviours across the organisation are discussed. Evaluations on training were not provided.

I acknowledge the providers response; however, I find the Service does not demonstrate effective risk management systems in place to manage risks for consumers. In coming to my finding, I acknowledge the service has provided education to staff on behaviour management and de-escalation techniques, however, with evidence in Standard 3 demonstrating ongoing concerns with the management of changed behaviours, I am not satisfied the governance system has ensured the training has been effective as the providers response did not evidence how they monitor the effectiveness of training provided. The provider’s response to the assessment team report, acknowledged deficits within their systems in monitoring high impact and high-prevalence risks, and implemented additional monitoring processes, inclusive of weekly multi-disciplinary huddles where risks to consumers are discussed and reviewed, however; this process was not in place at the time of the assessment contact and requires time to be embedded and reviewed for effectiveness.

Based on the evidence within the assessment teams report and provider’s response, I am not satisfied the service has effective risk management systems in place, and therefore, I find Requirement (3)(d) in Standard 8 not compliant.

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)