Performance

Report

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| Name of service: | Walkerville Residential Care Centre |
| Service address: | 160 - 178 Walkerville Terrace WALKERVILLE SA 5081 |
| Commission ID: | 6908 |
| Approved provider: | RSL Care RDNS Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 31 August 2023 to 1 September 2023 |
| Performance report date: | 23 October 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 Walkerville Residential Care Centre (**the service**) has been prepared by T 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 - 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 22 September 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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)(b) - Ensure that high impact high prevalence risks are managed effectively, especially in relation to medication and pain management.
* Requirement 7(3)(c) - Ensure staff understand their role and can deliver care as per the services policies and procedures.
* Requirement 8(3)(d) - Ensure governance procedures capture all risks and strategies are implemented to mitigate risks.
* Requirement 8(3)(e) – Ensure informed consent is obtained for restrictive practice. This includes discussion about the side effects of the restraint and ways to mitigate using them.

# 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. | Non-compliant |

Findings

As the Requirement assessed was found to be non-complaint the overall rating for this Standard in non-compliant.

The assessment team recommended Requirement (3)(b) as not met as care documentation for sampled consumers did not demonstrate effective management of high impact or high prevalence risks associated with the care of consumers, particularly in relation to falls, pain, medication and changed behaviours. The service uses several systems to manage consumer care including an electronic care system, medication management system and a paper based system. Documentation is not consistently being captured in these systems to ensure all risks to consumers are identified and mitigated to guide staff delivering care.

Three consumers who suffered falls did not have neurological observations or pain charting completed consistently following falls and one did not have their falls risk assessment updated despite it being reviewed following a fall in August 2023.

Three consumers who had conditions that require time sensitive medications did not always have the medications delivered, sometimes being more than an hour late. Management could not confirm the cause as to whether it was staff signing documentation late or it was an administration issue.

Three consumers requiring their blood glucose levels to be monitored, did not have the blood glucose levels documented consistently in the medication management system but did have them in the electronic care management system.

The service was not able to demonstrate effective management of changed behaviours in one consumer and did not have a restrictive practice authority in place or behaviour support plan in place. Two consumers who were provided psychotropic medication did not have effective strategies documented or implemented.

The service responded on the 22 September 2023 acknowledging where some things had not occurred but disputing some findings. Evidence provided included, but was not limited to, progress notes, charts, assessments, care plans and meeting minutes.

In relation to the falls management the service acknowledged where neurological observations were not completed and that for two consumers pain charting was not commenced following the falls, however, stating one did not show signs of pain through neurological observations. The consumer with the falls assessment that was not updated did not fall into the criteria according to the policy that they needed the falls risk assessment to be updated.

The service acknowledged that they did not always provide time sensitive medications for two consumers on time but there was no ill effects suffered by either consumer. Over the month of August 2023, one consumer was given 124 doses of medication with 12 outside the time range between seven and 78 minutes, the other had 217 doses with 13 outside of time range between four and 81 minutes. One consumer did not have a condition that requires time sensitive medications therefore they should not be considered as being late for time sensitive medications.

The three consumers did have their blood glucose levels recorded in the electronic care management system. General Practitioner (GP) directives, charts insulin administration and specialised care plans were provided to support this.

The consumer with changed behaviours has now had a behaviour and restrictive practice review in consultation with the family. The first consumer who was administered psychotropic medication occurred in the middle of the night and whilst the strategies were tried were appropriate for that time of the night as to not affect the others sleeping. The other strategies have been used over the month of August 2023 have been successful with only one administration of psychotropic medication in the month. The second consumer who had two as required psychotropic medications administered has had their behaviour support plan reviewed with further strategies to be used prior to the administration of as required psychotropic medications. Staff have been educated on the need to chart behaviours to inform care planning.

Additional training has been provided to staff in relation to high prevalence high impact risk and in July two new roles, a person centred practice specialist and a person centred practice lead. Their roles include, but is not limit to, reviews of serious incident response reports and restrictive practices and to educate on person centred care. The pharmacy delivery of time sensitive medications has also been improved with the medications packed separately and a presentation has been provided by a research foundation in relation to the condition for time sensitive medication.

It is expected the champions role will problem solve and attend to gaps in consumers care and support the care team and build stronger inclusive relationships by communicating effectively with consumers, families and staff members.

I have considered the information provided by the service and the assessment team’s report and I agree the service is not meeting this Requirement. Whilst the service has made improvements, these improvements will need time to be embedded into everyday staff practice.

For the consumers who had falls and who did not have neurological observations or pain charting completed, it leaves a gap in process where there is the possibility for adverse outcomes for the consumers. One consumer who complained of pain, did have a fracture and required hospital treatment was not commenced on pain charting immediately. Whilst a pain check was completed the following day in the afternoon and a hospital transfer occurred, there was a period of over 16 hours from when they first stated they had pain where it was not managed.

Whilst I acknowledge the improvements made to ensure staff are aware and the time sensitive medications are delivered separately, the impact to consumers can greatly affect them. While it was only on occasion medications were late, it can lead to worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating according to the advice for the medication.

I acknowledge that the consumers have been reviewed who were subject to restrictive practices and changes made to ensure the correct documentation and behaviour support plans are in place. However, at the time of the assessment contact one consumer did not have a behaviour support plan or a restrictive practice authority in place. Processes need to ensure when there is a change in consumer circumstances it does not impact them, and staff have the guidance to ensure they receive quality care.

In relation to the blood glucose levels I do agree with the Service that the blood glucose levels were taken and in the electronic care system and insulin charts showed insulin was given on sliding scale as it should have been.

It is for these reasons I find Requirement (3)(b) non-compliant.

# 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. | Non-compliant |

Findings

As the Requirement assessed was found to be non-complaint the overall rating for this Standard in non-compliant.

The assessment team recommends Requirement (3)(c) as not met as staff were not always competent in medication, falls and behaviour management and not all had a sound understanding of restrictive practice.

Three consumers were administered time sensitive medications late on several occasions.

On one occasion a consumer was administered another consumer’s medication after consultation with the clinical manager who granting permission, against the organisation’s policies and procedures resulting in the consumer receiving the wrong medication at the wrong dose.

Three consumers with falls did not have neurological observations or pain charting completed in line with the service’s policies and procedures.

Training records need to be reviewed manually to see if staff have outstanding training. The service provided information to show that approximately 25% of staff have not completed incident reporting and elder abuse training.

Management acknowledged the assessment team’s findings in relation to deficits in staff knowledge for time sensitive medications, falls management, pain charting and electronic care system data practices, indicating further reviews will be undertaken to improve compliance.

Information from Requirement 8(3)(d) showed staff were not competently record information such as notes reflecting pain assessment and charting but upon review, poor and inconsistent charting took place.

The service responded on the 22 September 2023 with records showing that currently the mandatory training compliance is 84.3%. An internal audit will be undertaken to identify any gaps which will be incorporated into an immediate corrective action plan which will be monitored by the Quality and Risk Team. The medication incident is part of a root cause analysis investigation.

I have considered the information provided by the service and the assessment team’s report and I agree the service is not meeting this Requirement. The service acknowledged the deficits in relation to the gaps identified in the report with staff knowledge. Whilst it was not explained why the staff were not competently completing their tasks the service has given an undertaking to identify any competency gaps and introduce an immediate corrective action plan to resolve the issues identified. I acknowledge the service have commenced this, but more time will be required to embed the practices.

It is for these reasons I find Requirement (3)(c) non-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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

As the Requirements assessed were found to be non-complaint the overall rating for this Standard in non-compliant.

The assessment team recommended Requirements (3)(d) and (3)(e) as not met as the service did not demonstrate risk management in relation to high impact and high prevalence risks including falls, behaviour and pain. The incident management system has not identified significant medication errors, and clinical governance in relation to restrictive practices is ineffective. Clinical governance has not identified several consumers who are subject to restrictive practice and chemical restraint is not always used as a last resort.

Report outlined how consideration of risk is not always undertaken or identified by the service including:

* Several errors where time sensitive medication was given more than an hour late, yet the incident management system did not identify this as an issue.
* Pain charting or neurological observations were not always completed as per procedure.
* The system of checking progress notes failed to identify one consumer was in pain and had a fracture which delayed their transportation to hospital by approximately 17 hours.
* Risks were not considered when two consumers requested their doors to be locked to prevent a consumer with wandering behaviours from entering.
* Different systems are used to record the same thing such as medication which poses a risk to consumers by staff not consulting all systems.
* One consumer did not have it recorded on the system they required their medications to be crushed leaving a risk of choking.

Whilst there is a clinical governance framework, it is not always effective in relation restrictive practice.

* Six named consumers did not have environmental restrictive authorities in place.
* One consumer with a change in cognition who was now no longer able to leave the service unaccompanied did not have the risks considered or an environmental restrictive authority completed.
* Chemical restrictive practice is not always used as a last resort and is used to manage behaviour as a primary strategy.

The service responded on the 22 September 2023 with commentary describing the risk management and clinical governance systems and explaining one incident from the report was a system error which has now been rectified and another representative was happy with the communication and plan for the consumer. Other information included risk and clinical meetings and agendas, signed restrictive practice authorities, progress notes, medication profiles and a consumer risk indicator document. The service stated that all chemical restrictive practice is recorded correctly and that environmental restrictive practices were in place. They have rectified the issues in relation to one consumer with changed cognition who could no longer go outside and have now put the appropriate authorisation in place. They have also added continuous improvement items such as education, review of care Champion roles, review of medications and handover processes.

I have considered the information and I find that the service is not meeting these Requirements.

At the time of assessment there were risks present that were not identified through the risk management process such as late time sensitive medications, pain not being charted, and neurological observations not completed as per policies and procedures. It is not clear whether the incidents of time sensitive medications were reported as an actual incident for those that were over an hour late, but the governance processes did not detect that the medications were late therefore there was no continuous improvement undertaken to ensure the medications are delivered within the timeframes required of the time sensitive medications. Whilst the system error in relation to the consumer with crushed medication has now been rectified, at the time of the assessment it was a risk that was there that had not been detected.

In relation to clinical governance, I acknowledge the service states that all authorities were in place and the psychotropic medication register had identified psychotropic medications correctly as chemical restraint. However, I am not convinced that informed consent has been undertaken as required for the use of restrictive practice. The email on the response does not show that risks are considered, only that the medications have been reviewed and are appropriate. Additionally, the representative of the consumer who did not have an environmental restraint prior to the visit, did know the consumer could no longer leave the service but did not recall a conversation about it being a restraint or the discussion of risks.

I acknowledge the organisation does have a risk management system and clinical governance framework with policies and procedures to guide staff and processes to manage risks. There are escalation processes to through organisation to ensure risks are managed. I acknowledge the service has put into place continuous improvement to ensure any gaps in the clinical governance and risk management systems are effective, but it will take time to ensure these actions are effective.

It is for these reasons I find Requirement (3)(d) and (3)(e) are non-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)