Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Walkerville Residential Care Centre |
| Commission ID: | 6908 |
| Address: | 160 - 178 Walkerville Terrace, WALKERVILLE, South Australia, 5081 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 23 January 2024 |
| Performance report date: | 29 February 2024 |
| Service included in this assessment: | Provider: 1599 RSL Care RDNS Limited  Service: 4319 Walkerville Residential Care Centre |

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 M Glenn, 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 consumers, representatives, staff and management;
* the provider’s response to the assessment team’s report received 13 February 2024. The response includes commentary and supporting documentation directly relating to the deficits identified, including actions taken in response, as well as a plan for continuous improvement outlining the issues, planned actions, progress and actual completion dates; and
* a performance report dated 23 October 2023 for an assessment contact undertaken 31 August 2023 to 1 September 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **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.

**Standard 3 requirement (3)(b)**

* Ensure staff have the skills and knowledge to identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including skin integrity/wounds, behaviours, and falls, specifically post falls care.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks.

**Standard 7 requirement (3)(c)**

* Ensure staff competency, skills and knowledge are assessed, monitored and tested to ensure staff are competent to undertake their roles.

**Standard 8 requirement (3)(e)**

* Review the organisation’s clinical governance framework, particularly in relation to how provision of clinical care is monitored and deficits identified and actioned.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 Quality Standard is assessed as non-compliant as the one requirement assessed has been found non-compliant. The assessment team recommended requirement (3)(b) not met.

**Requirement (3)(b)** was found non-compliant following an assessment contact undertaken in August/September 2023 as high impact or high prevalence risks relating to falls, pain, medication and changed behaviours were not effectively managed. The service implemented a range of improvement actions to address the non-compliance, including, but not limited to, conducting an internal audit and in consultation with the pharmacy, packed all time sensitive medications separately; commenced four consumers on a monitoring program to assist in the management of falls; and provided information to staff in relation to behaviour management.

At this assessment contact, the assessment team found risks relating to wounds, pressure injury prevention and skin integrity, falls and behaviours were not effectively managed. Consumers said staff are not aware of their current needs and they have to remind staff of the care and services they require, especially night staff and agency staff. Care staff were not knowledgeable of high risk consumers’ care needs, including consumers with pressure wounds and repositioning requirements, or of personalised interventions and strategies for consumers with behaviours and restrictive practices.

Wound charts are not always commenced in a timely manner when a wound is identified, wounds are not being identified until stage 2 or unstageable, and wound photographs are not consistent. Pressure area interventions are not reviewed or implemented when consumers sustain a pressure wound, and while staff work with consumers on a regular basis, they are unable to identify consumers with pressure wounds. While one consumer was identified with an unstageable wound, no related management strategies have been implemented, the skin care plan has not been updated and no additional interventions have been implemented, including repositioning.

All areas on behaviour charts have not been completed, including triggers, description of the behaviour or interventions. Where generic strategies are ineffective, charting or progress notes do not demonstrate any additional strategies have been trialled, or the impact on the consumer or other consumers. Staff confirmed one consumer is physically resistive to care and hits out at staff during care needs daily. These behaviours have not been captured in behaviour monitoring charts, progress notes do not identify these regular behaviours or actions taken and incident reports have not been completed.

Documentation for one consumer who had a fall in November 2023 does not show the consumer was assessed in a timely manner to identify pain from a fracture until this was reported by the consumer’s representative. There is no evidence to show actions or additional clinical care implemented for 12 hours after being reported by the representative until the consumer was sent to hospital for further review. On return from hospital, assessments and care plans were not updated to reflect hospital recommendations. Assessments, including mobility and falls risk were not completed until the following day and were not reflective of the consumer’s current mobility needs. While a pain assessment was completed the day following return from hospital, the assessment did not include pain experienced related to the fracture.

In their response, the provider acknowledges deficits identified by the assessment team. Actions taken in response include, but are not limited to, providing staff further education on pressure injuries, wound care, skin checks, behaviour charting, escalation and pain monitoring. Reviews and/or referrals have been undertaken for named consumers, including to general practitioners, wound specialists and behaviour specialists. For a consumer identified with physically resistive behaviours, the provider states behaviour support strategies have been successful in reducing physical behaviours, therefore, charting and incident forms have not been completed. For the consumer who had a fall, the provider acknowledges a delay in clinical assessment following escalation by the representative. A falls risk assessment completed post fall in November 2023 was included in the response.

I acknowledge the provider’s response. However, I find high impact or high prevalence risks relating to skin integrity/wounds, behaviours and post falls management have not been effectively managed. Changes to skin integrity have not been identified resulting in wounds not being identified until they are stage 2 pressure injuries, wound charts are not consistently initiated in a timely manner, and wound photographs are not consistent. Behaviour charting is not consistently completed to enable behavioural changes to be identified or effective management strategies to be implemented to minimise risks to the consumer and others. For one consumer, post falls management was not effective, with staff being notified of the consumer’s experience of pain by the consumer’s representative. Additionally, appropriate and prompt actions were not initiated following the consumer’s return from hospital, with the care plan not updated to reflect the consumer’s changed needs to guide provision of care and the consumer’s pain experience related to a diagnosed fracture not considered through assessment processes. I find such practices do no ensure risks related to consumers’ clinical care are effectively monitored, or changes identified to enable prompt action to be taken. I acknowledge the actions planned to address the deficits identified outlined in the provider’s response. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as the one requirement assessed has been found non-compliant. The assessment team recommended requirement (3)(c) not met.

**Requirement (3)(c)** was found non-compliant following an assessment contact undertaken in August/September 2023 as staff were not always competent in medication, falls and behaviour management and not all had a sound understanding of restrictive practice. The service implemented a range of improvement actions to address the non-compliance, including, but not limited to, registered nurses and management completing drug calculations and policy modules and recertifying medication competent care staff; providing staff training in time sensitive medications; rostered an additional four staff across seven days and an additional staff member for night shift, with minimum qualifications of medication competent care staff to support the registered nurse; and created a learning and development officer position to facilitate training across all South Australian based services operated by the organisation.

At this assessment contact, the assessment team found workforce competence in relation to management of wounds, falls and behaviours was lacking, and system training records in relation to staff completion were incomplete or not provided. Four of five consumers said the majority of staff are competent, however, there is often new and/or agency staff who need additional training. Continence management and mobility were described as being impacted. While three care staff described monitoring and reporting changes to consumers’ skin integrity, and confirmed receiving related mandatory training, this has not been effective in the early identification of changes for some consumers. Management said staff have completed behaviour management training, however, no records were produced and deficiencies in monitoring of staff competency in relation to behaviour management, including completion of behaviour monitoring charts have been identified. The service was asked to provide training records in relation to mandatory training, restrictive practices, falls management, skin integrity and wound management, and while a training folder was provided which showed some evidence of learning and development activities, some records were incomplete.

An agency staff member did not receive a handover, did not know what medications were due, and had not been informed which consumers had COVID-19, despite positive cases in the area they were scheduled to work in. A care staff said a similar situation occurred with a different agency staff member the previous week, where they had not been provided an orientation of the area.

In their response, the provider states the clinical management team are now focussing on follow-up education with staff, as required, following their weekly visual review of wounds and high risk consumers. An education corner has been created to provide additional information on skin checks, pressure injuries and behaviour management. Weekly skin integrity checks have commenced to ensure compliance, early detection and escalation of any concerns. The orientation/induction process for agency staff has been reviewed to ensure they are directed to the registered nurse in charge.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the knowledge to effectively perform their roles. In coming to my finding, I have considered the outcomes for consumers highlighted in Standard 3 Personal care and clinical care requirement (3)(b) which indicate staff skills and knowledge are not adequate to ensure effective identification, management and monitoring of high impact or high prevalence clinical risks or to identify changes in consumers’ condition to enable prompt action to be taken. While training records show staff have received training in relation to skin integrity, and management said training has been provided to staff on behaviour management, deficits in the provision of care relating to these specific areas has been identified. I find this demonstrates the organisation’s systems to monitor whether staff skills are effective and that care is being delivered in line with the organisation’s policies, procedures and clinical governance framework have not been effectively applied. While effective information exchange processes for agency staff did not occur on the day of the assessment contact, I have considered that the provider’s response demonstrates appropriate actions have been initiated to address this deficit. I acknowledge the actions planned to address the deficits identified outlined in the provider’s response. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the two requirements assessed has been found non-compliant. The assessment team recommended requirements (3)(d) and (3)(e) not met.

**Requirement (3)(d)**was found non-compliant following an assessment contact undertaken in August/September 2023 as effective risk management in relation to high impact or high prevalence risks, including falls, behaviour and pain was not demonstrated and the incident management system had not identified significant medication errors. At this assessment contact, the assessment team found whilst the organisation has continued with daily progress note reviews and undertaken staff training in response to the non-compliance, effective risk management system and practices with adequate monitoring and oversight was not demonstrated. There are systems to analyse and trend data across the multi-tiered organisational structure, however, core data is subject to workforce input for entry and accuracy which is not embedded in staff knowledge or practice, resulting in data analysed being misreported.

Care staff could not consistently describe processes and care needs to identify   
and support high impact or high prevalence risks, such as skin integrity, consumers with wounds and repositioning requirements, behaviours and restrictive practice, appropriate documentation of incidents or adequately reporting and recording changes. Risks and inconsistencies through daily progress note reviews relating to wounds, pressure area care, skin integrity, falls and behaviours has not been identified, with documentation recording poor assessment, charting, monitoring and reporting practices. Staff training did not demonstrate an effective or embedded knowledge of high impact or high prevalence risks, with staff describing inconsistent processes for identifying and accurately documenting information which is used to formulate clinical data, trending and analysis.

Errors in reporting and recording of incidents in the electronic management system were identified where staff had not classified information correctly. Incident data generated for December 2023 records multiple entries under the heading ‘other’ with a descriptor, instead of the correct classification. Internal documentation used to oversee high risk consumers is not consistently documented with dates, headings and actions to track changes. Meeting agendas for the clinical governance committee dated December 2023 and Board meetings dated November 2023 are unclear where risk is raised and discussed at these levels of the organisation.

In their response, the provider states the operations manager and quality compliance team are now meeting with the home leadership team weekly to ensure effective monitoring of high impact or high prevalence risks. All levels of staff are being provided with information relating to these risks and the importance of identifying, charting, reporting and escalating concerns. Operations and the home leadership team have been provided with further orientation to the organisation’s reporting structures to provide clarity on how risk is discussed and monitored throughout the organisation. The provider’s response outlines the organisation’s reporting structures from the service to the governing body and indicates monthly clinical indicator reports are completed, trends monitored and outcomes discussed and escalated. Monthly clinical indicator reports for a three month period were also included in the response demonstrating where incidents are reported as ‘other,’ these have been investigated and appropriately actioned.

I have come to a different finding to the assessment team’s recommendation of not met and find requirement (3)(d) compliant. I do not consider the deficits highlighted indicative of systemic failures of the organisation’s overall risk management systems and practices. The provider’s response demonstrates there are clear reporting processes between the service and the governing body where reports are tabled and emerging risks are escalated. Clinical indicator audit forms included in the provider’s response demonstrate where incidents are recorded as ‘other,’ a trend analysis of this data records the type of incidents these relate to, as well as recommended actions. The audit forms for the three months provided show a downward trend in the number of incidents classified as ‘other.’ I do, however, consider the evidence presented relating to lack of staff knowledge to identify and support high impact or high prevalence risks, not adequately reporting and recording changes, lack of identification of inconsistencies in daily progress note reviews, and poor assessment, charting, monitoring and reporting practices indicates staff practice is not effectively monitored. I also consider these deficits do not effectively enable improvements to the quality of clinical care provided to consumers to be identified and implemented. As such, I have considered this evidence in my findings for requirement (3)(c) in Standard 7 and requirement (3)(e) in this Standard.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance compliant.

**Requirement (3)(e)** was found non-compliant following an assessment contact undertaken in August/September 2023 as clinical governance had not identified several consumers who were subject to restrictive practice and chemical restraint was not always used as a last resort. The service implemented a range of improvement actions to address the non-compliance, including, but not limited to, completing a review of restrictive practice authorisations; and ensuring all consumers residing within and outside of the memory support unit unable to leave have an environmental restraint authorisation in place.

At this assessment contact, the assessment team found the clinical governance framework, including structures to monitor and escalate risks, and systems to ensure the safety and quality of clinical care, is not always effective in identifying deficits in care relating to wounds, falls and behaviour management. While there are systems to ensure clinical care data is correctly reported, these systems are not always effective in identifying consumers with compromised skin integrity and/or early detection of pressure injuries; inconsistent information in care plans in relation to diabetic management and falls risk scores; inaccurate falls and behaviour incident reporting; lack of personalised interventions and strategies for behaviours; and inconsistent charting of behaviours.

During the assessment contact, the memory support unit was a ‘red zone.’ Donning and doffing zones were in the same spot without clear demarcations, two bins were located opposite a consumer’s room, which was not in line with infection control guidelines, and an agency staff had not been given handover of infectious consumers one hour into their shift. There was evidence, however, that consultation occurs with medical officers in relation to infections, organisation wide systems are in place to prevent, manage and control infections and staff receive training in infection control. Antibiotic usage is monitored and reviewed at both a service and organisational level. Open disclosure is an agenda item for staff meetings, staff receive regular training in open disclosure, and open disclosure is practiced at all times, including when consumers have falls or incidents occur.

In their response, the provider acknowledges processes were not followed in relation to compromised skin integrity and/or early detection of pressure injuries and in response, new measures to support improvement have been implemented, including further education and increased monitoring. The provider acknowledges ongoing improvement is required in relation to incident reporting and accuracy, including for falls and behaviours. In relation to the memory support unit, follow-up was undertaken in response to the assessment team’s observations.

I acknowledge the provider’s response. However, I find the clinical governance framework overall has not been effective in ensuring good clinical results for consumers. Deficits identified in relation to skin integrity/wounds, behaviour management and falls have not been identified by the service’s own monitoring processes. These monitoring processes include, but are not limited to, daily progress note reviews, audits, and post incident reviews. I do, however, acknowledge effective systems and processes relating to antimicrobial stewardship and open disclosure were demonstrated. I acknowledge the actions planned to address the deficits identified outlined in the provider’s response. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement. In relation to restraint, while the assessment team’s report indicates audits have not been conducted following identification of non-compliance relating to restrictive practices in August/September 2023, there is no evidence presented to demonstrate restrictive practices are not being identified, managed or monitored or the use of restraint is not being minimised.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-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)