Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Waratah Lodge |
| Service address: | 6 Arnott Street WAGIN WA 6315 |
| Commission ID: | 7118 |
| Approved provider: | Wagin Frail Aged Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 29 November 2022 to 30 November 2022 |
| Performance report date: | 10 January 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 Waratah Lodge (**the service**) has been prepared by K Richards 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 consumers/representatives, staff, and management;
* the provider’s response to the Assessment Team’s report received on 20 November 2022; and
* the Performance Report dated 5 May 2022 in relation to the Assessment Contact conducted on 22 to 23 February 2022.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **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

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 staff have the skills and knowledge to:
  + Undertake appropriate assessment and monitoring following falls, including monitoring for pain and deterioration.
  + Undertake appropriate assessment and review of wounds and document detailed outcomes to enable effective monitoring of wound progression.
  + Undertake appropriate assessment of psychotropic medications, identifying when they may be used as chemical restraint, and ensuring care planning includes obtaining informed consent and directives to monitor following use.
* Ensure policies and procedures in relation to assessment and monitoring for falls, wound care and use of psychotropic medications, including when used for chemical restraint, are effectively communicated, and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, and guidelines in relation to assessment, care planning and review.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirements (3)(a) and (3)(g) were found non-compliant following an Assessment Contact undertaken from 22 to 23 February 2022.

* Under Requirement (3)(a), the service was unable to demonstrate delivery of safe and effective care in relation to wounds, falls and medication management.
* Under Requirement (3)(g), the service did not demonstrate minimisation of infection related risks, and did not have any antimicrobial stewardship to support the appropriate administration of antibiotics.

Requirement (3)(a)

The Assessment Team’s report for the Assessment Contact conducted on 29 to 30 November 2022 did not include evidence of actions taken by the service in response to the non-compliance in relation to wounds and falls. Actions taken in relation to medication management included:

* Provision of training to staff in medication management.
* Introduction of a Registered nurse on site 9 days per fortnight to oversee clinical care, and a second Registered nurse to commence full time in December 2022.

The Assessment Team found the service was unable to demonstrate delivery of care that is best practice in relation to falls, wound care and restrictive practices, and provided the following information and evidence relevant to my finding:

* The service has updated their policy for falls prevention to include a ‘responding to falls’ checklist, directing staff to record neurological observations if a head strike has occurred, check for injuries and complete an incident form. A falls procedure protocol printout includes directives for frequency of monitoring for over 24 hours after the fall. However, 4 care staff stated they are not required to do any ongoing monitoring after a fall, and management confirmed they do not follow the falls procedure, with directions for monitoring to be provided by the Registered nurse.
* Two consumers did not have ongoing monitoring for pain or deterioration following falls, despite both consumers hitting their heads, with one set of vital signs taken immediately following the fall but no further documentation sighted.
* Consumer A sustained bruising and swelling to their face following a fall on 26 November 2022, however, directives to photograph the injury and commence a wound chart were not given until 28 November 2022 and there were no directives for assessment and monitoring of pain despite the consumer complaining of pain and being administered additional pain relief. The consumer also had a low blood pressure reading, which was not identified as being outside their normal/acceptable range, was not escalated to clinical staff, and was not reviewed or repeated until 3 days later. Management acknowledged this should have been identified and trigger follow up monitoring of blood pressure.
* The service has no current policy for skin and wound care to guide best practice. Wound charts for 6 sampled consumers did not demonstrate regular assessment of the wound, failing to capture details of the wound including description of healing and measurements and pain levels. Photographs were not taken regularly to demonstrate progress, with examples given of two consumers’ wounds without photograph for 6 and 9 weeks. Whilst management advised the wounds were healing, documentation was not available to the Assessment Team to verify this.
* There was no evidence indicating informed consent had been obtained for three consumers receiving psychotropic medication. For two of these consumers, they did not have a diagnosis of insomnia to support the use of the prescribed psychotropic medication.
* Information and evidence in the Assessment Team’s report under Requirement (3)(e) in Standard 8 Organisational governance demonstrates one representative was unaware the consumer had been prescribed, and one consumer was unaware of risks associated with the use of, psychotropic medication. There was no evidence indicating monitoring has occurred following administration of psychotropic medication to understand whether it has been effective and ensure there are no adverse effects. Directions in relation to monitoring of consumers following administration of psychotropic medication was not documented in sampled consumers’ care plans.

The provider’s response indicates they accept the recommendations of the Assessment Team, and has submitted an action plan to remedy issues identified during the Assessment Contact. This action plan includes, updating of policies and procedures in relation to falls management, inclusive of pain management, and wound care, and communication of changes to staff. The provider’s response confirms further actions taken, including the confirmed hiring of the second Registered nurse to assist address areas of ongoing non-compliance. I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Assessment Contact, each consumer did not receive safe and effective care that was best practice, tailored to their needs and optimised their health and well-being.

In relation to post falls management, I have considered that while the service has a policy to guide staff in responding to falls, staff are unaware of their obligations under the policy and management confirmed it is not followed. For 2 consumers who experienced falls, ongoing monitoring of vital signs, pain and deterioration either did not occur or was minimal, which places the consumer at risk of harm.

In relation to wounds, I have considered that best practice wound care was not provided, as for 6 sampled consumers, regular assessment and documentation of the wound did not occur to ensure interventions were effective and wounds were healing.

While the Assessment Team referenced use of psychotropic medications under a heading of ‘restrictive practice’, I do not consider the report demonstrates examples where psychotropic medications have been used as chemical restraint (being used for the purposes of altering the consumers’ behaviour). However, I find it is reasonable to expect records of informed consent and authorisation for use of psychotropic medication be maintained, and for care plans to include directives for monitoring of effectiveness and adverse effects of the medication. This did not occur for three sampled consumers to ensure the medication is being used as safely as possible.

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

Requirement (3)(g)

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provision of training to staff in infection control and outbreak management processes.
* Development of new policies in relation to antimicrobial stewardship and updating existing policies including infection prevention.
* Recruitment of a new Registered nurse with an infection control background.
* Undertaken monitoring of use of antibiotics during monthly clinical meetings.

The Assessment Team were satisfied these actions and improvements were effective, as the service was able to demonstrate infection related risks have been minimised through implementation of standard and transmission based precautions to prevent and control infection, and practices to promote appropriate antibiotic usage. The Assessment Team provided the following information and evidence relevant to my finding:

* Management spoke of recruitment of an external consultant to oversee and direct infection control, and actions taken in response to their audits and feedback.
* The service has undertaken review of documents relating to infection control and a review of the ‘outbreak management plan and infection prevention risk assessment’ was updated following a COVID-19 outbreak in August 2022.
* Staff members were able to describe standard precautions, and describe training in relation to infection control and antimicrobial stewardship.
* Management described actions to ensure effective use of antibiotics, including working with the Medical officer, ensuring non-pharmacological measures are implemented whilst waiting for pathology results, demonstrated through review of care files.
* Whilst the service does not have a current Infection Prevention and Control Lead, management anticipates the new Registered nurse will undertake the necessary studies to take on this role.

For the reasons detailed above, I find Requirement (3)(g) in Standard 3 Personal and clinical care 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. | Non-compliant |

Findings

Requirement (3)(c) was found non-compliant following an Assessment Contact undertaken from 22 to 23 February 2022, where it was found staff were not competent in the management of wounds, falls and medication. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Recruitment of a full time Registered nurse to guide staff on clinical care and management of falls.
* Reinforcement of established training procedures to medication competent staff.
* Provision of additional training to all staff.

The Assessment Team was satisfied these actions and improvements were effective and recommended the service meets this Requirement. However, based on the evidence in Standard 3(3)(a) in relation to wound care and monitoring following falls, I have come to a different conclusion and find this Requirement non-compliant. Relevant evidence included:

* Whilst the service has a falls procedure protocol detailing monitoring requirements for over 24 hours following a fall, 4 care staff interviewed said they were not required to do any further monitoring after an initial assessment immediately after a fall.
* Clinical documentation for 2 consumers did not demonstrate monitoring in alignment with the protocol, despite both consumers noted as hitting their heads during the fall.
* There was no evidence of regular monitoring for pain or deterioration nor directives for same within progress notes, despite documentation of bruising and swelling to the side of Consumer A’s face following the fall, and ongoing use of additional pain relief due to complaints of pain. When Consumer A’s blood pressure was recorded as lower than her normal readings after the fall, it was not reviewed or rechecked for 72 hours.
* Wound assessments, including recording measurements and taking photographs of wounds, were not being conducted on a regular basis, and review of wounds were not being conducted. The Assessment Team found the service had no current policy for skin and wound care to guide best practice.

The provider has submitted an action plan to remedy issues identified during the Assessment Contact, which includes, updating of policies and procedures in relation to falls management, inclusive of pain management, and wound care, and communication of changes to staff. They also confirm further actions taken, including hiring a second Registered nurse to assist address areas of ongoing non-compliance.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Assessment Contact, the workforce was not competent to effectively perform their roles.

I have considered that staff were unaware of their obligations under the service’s post falls management policy. For two consumers who hit their heads during falls, post fall monitoring did not occur in line with the policy, and they were not monitored for pain or deterioration, which placed these consumers at risk of harm. Additionally, staff were not competent in providing best practice wound care, as for 6 sampled consumers, regular assessment and documentation of the wound did not occur to ensure interventions were effective and wounds were healing.

I have also considered that deficits in staff competency identified, such as post fall monitoring and wound care, are consistent with those which resulted in the previous non-compliance, indicating improvements are either not effective or have not been fully embedded. 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. | Compliant |

Findings

Requirements (3)(d) and (3)(e) were found non-compliant following an Assessment Contact undertaken from 22 to 23 February 2022.

* Under Requirement (3)(d) it was found the service was unable to demonstrate use of an effective risk management system, particularly in relation to effective management of high impact and high prevalence risks, supporting consumers to live their best life and responding to allegations of abuse and neglect appropriately.
* Under Requirement (3)(e) it was found the service was unable to demonstrate a clinical governance framework in relation to antimicrobial stewardship, with an absence of policy and associated strategies to promote appropriate antibiotic use. The service was also unable to demonstrate clinical governance framework in relation to use of psychotropic medication, with an absence of information on use of psychotropic medications, and lack of consent or authorisation for the use of the medication.

Requirement (3)(d)

The Assessment Team’s report for the Assessment Contact conducted on 29 to 30 November 2022 did not include evidence of actions taken by the service in response to the non-compliance for Requirement (3)(d). However, the Assessment Team found the service demonstrated identifying and responding to abuse and neglect of consumers, and effective use of an incident management system which informed continuous improvement activities.

The Assessment Team provided the following evidence relevant to my finding:

* Staff members said they received training on abuse and neglect and reporting of Serious Incident Response Scheme (SIRS) incidents.
* Reported incidents included investigations and responses, and appropriate reporting through SIRS.
* Demonstrated use of a risk management framework to support consumers to choose to take risk using a person centred approach.

The Assessment Team was not satisfied the service consistently managed high impact and high prevalence risks in relation to falls, with staff not undertaking neurological observations in alignment with instruction in the current falls flow chart. As the core deficits relate to best practice care provision and staff competency, rather than organisational governance, I have considered this information under my findings for Standard 3 Requirement (3)(a) and Standard 7 Requirement (3)(c).

Based on the information summarised above, I find Requirement (3)(d) in Organisational governance compliant.

Requirement (3)(e)

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Development of new policies in relation to antimicrobial stewardship, use of restrictive practices, and open disclosure.
* Engaged an external provider to complete a medication review, including identification of psychotropic medications, with results provided to the Medical officer to take action in response to recommendations.

The Assessment Team were satisfied these actions and improvements in relation to antimicrobial stewardship were effective, as a new policy has been drafted and is due for release in January 2023, and the service demonstrated ongoing monitoring of use of antibiotics during monthly clinical meetings. The Assessment Team also found the service has a current policy directing staff on use of open disclosure, with understanding and application demonstrated through staff interviews and review of incident documentation.

However, while the service has introduced a register for psychotropic medications, the Assessment Team felt the service did demonstrate use of an effective governance framework in relation to minimising the use of restraint. Specifically that the service did not follow procedural and legislative requirements for consumers subject to chemical restraint. The Assessment Team provided the following information and evidence relevant to my finding:

* Documentation for 3 consumers prescribed psychotropic medication did not include appropriate authorisation and consent for the administration of the medication.
* Consumer B is prescribed a benzodiazepine to assist with sleeping but does not have an associated diagnosis, however, the representative advised they have been taking medication for sleep for some time and they wish for this to continue.
* Consumer C is prescribed an anti-depressant medication for a diagnosis of depression, however, the consumer and their representative were unaware of the diagnosis or use of the medication.
* Consumer D is prescribed a benzodiazepine as a muscle relaxant as part of a broader pain management strategy, however, the consumer said the service had not discussed any risks and did not monitor for adverse effects of the medication.

The provider’s response indicates they accept the recommendations of the Assessment Team, and has submitted an action plan to remedy issues identified during the Assessment Contact. These include, updating policies and procedures in relation to the use of restrictive practices, obtaining consent and authorisation for use of psychotropic medications, access training and information for nurses on psychotropic medication, and identifying chemical restraint for new consumers on admission. I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response. I have come to a different view than the Assessment Team and find the evidence of the organisation’s clinical governance framework is effective.

The *Quality of Care Principles 2014* defines chemical restraint as ‘a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a recipient’s behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition, or end of life care for the care recipient’.

The examples within the Assessment Team’s report do not reflect use of psychotropic medication as chemical restraint for any of the sampled consumers, as they are not being administered for the purpose of influencing their behaviour. Consumer C is prescribed medication for the treatment of a diagnosed mental disorder, Consumer D is prescribed medication for treatment of a physical illness or condition, and Consumer B is prescribed medication to treat pain. The examples provided do not demonstrate failure to follow legislative requirements in relation to use of chemical restraint, and while there are deficits in relation to the absence of consent and authorisation for the use of psychotropic medications, along with monitoring for effectiveness or adverse effects, I find these failures relate to best practice care delivery. I have therefore considered these deficits under Standard 3, Requirement (3)(a).

I have considered that the service has implemented a register of psychotropic medication to monitor usage, ongoing monitoring of antibiotics is occurring through monthly clinical meetings, a new policy for antimicrobial stewardship is drafted and ready to be implemented, and staff demonstrated a good understanding of open disclosure.

For the reasons detailed above, I find Requirement (3)(e) in Organisational governance 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)