Performance

Report

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| Name: | Wellington Park Private Care |
| Commission ID: | 5362 |
| Address: | 16 Balmoral Street, WELLINGTON POINT, Queensland, 4160 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 6 February 2024 |
| Performance report date: | 5 March 2024 |
| Service included in this assessment: | Provider: 1659 Superior Care Group Pty Ltd  Service: 3707 Wellington Park Private Care |

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 Wellington Park Private Care (**the service**) has been prepared by Bruce Bassett, 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 23 February 2024.

# Assessment summary

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| 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.

* The service must ensure consumers receive safe and effective care, particularly with respect to medications, falls, diabetes and restrictive practices including chemical restraint.
* The service must ensure it has robust governance systems to support staff practice, particularly in relation to information management, workforce governance and regulatory compliance.

# 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 Assessment Team report indicated that consumers interviewed said they were happy with the clinical and personal care they were receiving. However, review of documentation, and interviews with management and clinical staff identified deficiencies in the management of time sensitive medication, neurological observations following falls, diabetic management, and restrictive practices.

Review of clinical documentation of three consumers who are prescribed time sensitive medication evidenced it was being administered late or not administered at all. For example, a named consumer was prescribed anti-coagulant medication at 1600 daily. A review of the medication chart showed this was administered late on multiple occasions in the week prior to the Assessment Team visit. The consumer stated that their ‘warfarin is all over the place, it always comes in the afternoon or evening, but it can be hours late.’

Another named consumer with a diagnosis of Parkinson’s disease is prescribed medication four times a day. Review of their medication chart for the seven days prior to the visit showed the medication was unable to be administered seven times, including three times in one day. Clinical staff advised the Assessment Team the consumer is often asleep and cannot be woken for the medication. It was said both the prescribing Medical Officer (MO) and the consumer’s representative are aware of this. Clinical staff were unable to provide evidence in relation to the MO and representative being informed of the risks associated with missed medications. Management did provide a progress note from mid-2023 stating the representative was aware that occasionally the consumer was sleepy, and medication could not be administered.

Management advised there could be an issue with recording the time medications are administered due to system limitations and acknowledged that education around time-sensitive medication, its administration and record management was needed.

In responding to this issue, the approved provider said that following identification of the issue, the Clinical Nurse Coordinators (CNC) conducted immediate training with registered staff on 6 and 7 February 2024. The response said an audit has since been conducted covering a ten-day period and seven incidents were identified where time sensitive medications had not been administered within an acceptable time frame. As a result, medication incidents were completed, and staff have received further education. The CNC continues to work with staff to drive the necessary improvement needed.

With respect to the named consumer whose medications were sometimes missed as they were asleep, the provider response advised discussions have been held with their representative concerning the issue, a dignity of risk process has been completed and the matter has been included in the agenda for the next clinical staff meeting.

With regards to falls management, review of care documentation of some consumers who had a recent fall found that while post fall assessments were completed by registered staff and reviews by physiotherapists were completed, neurological observations following falls were not completed and recorded according to the organisational policy. Clinical staff interviewed described the policy for neurological observations following a fall was to record the observations over 24 hours, which was contrary to the updated policy of 72 hours. Clinical staff said they had not received any information regarding the updated policy.

Management stated the falls management policy had recently been updated and this change had been communicated to clinical staff verbally.

The provider response to this issue advised the CNCs have discussed the new policy with registered staff and are now reviewing falls management daily to ensure the neurological observations are being completed as required to support appropriate clinical care.

The response advised that should it be identified that observations are not being completed, the CNC will ensure the required timeframe for monitoring is re-established and the staff involved will receive further education. The revised falls policy will also be discussed at the next clinical staff meeting.

The Assessment Team report indicated review of clinical documentation of two consumers who require insulin to manage diabetes revealed no diabetic care plans were in place. For example, review of one named consumers’ care documentation indicated fourteen instances where their Blood Glucose Levels (BGL) had not been recorded over a three-week period. There was no diabetic care plan in place and no instructions on who should be notified if the BGLs are outside of prescribed parameters. Another named consumer experienced a hypoglycaemic episode, with insulin given as prescribed, but no notification had been made to their MO.

Management acknowledged consumers should have a diabetic care plan in place, with reportable parameters identified, with the consumer’s MO to be notified if outside of these parameters.

With regards to diabetes management, the provider response acknowledged that no diabetic care plans had been in place for the two named consumers. Diabetes management plans for them had been completed on 8 and 9 February 2024 and these include their required parameters for BGLs and the actions to be taken should readings be outside those parameters. Consumer diabetic plans have been added to the consumer high risk, high impact register managed daily by the CNC. This will also form part of daily clinical reviews and weekly clinical governance reviews going forward.

With regards to Restrictive Practices, the Assessment Team noted the service had recently reviewed environmental restraints and authorisations had been electronically sent to representatives, with some authorisations completed and returned to the service at the time of the Assessment Contact. Management said they would be following up outstanding authorisations.

In relation to chemical restraint, management self-reported a number of issues to the Assessment Team:

* They were unable to confirm consumers prescribed medication that could be considered a chemical restraint had the appropriate diagnosis and indication for use.
* The Psychotropic register was incomplete, with review dates, diagnosis and monitoring absent.
* MO reviews of the ongoing requirement for medication were not current.
* Consent forms in relation to the use of restrictive practice were not current.
* Behaviour support plans had not been reviewed or personalised to reflect consumers individualised behavioural support needs.

Management advised they had commenced reviewing the psychotropic register, with all consumers identified as being subject to chemical restraint to be reviewed by the MO. Training is to be provided to all staff on restrictive practices by Dementia Services Australia and is awaiting final approval from senior management. The CNCs will review and update all behaviour support plans.

The provider response to the Assessment Team report confirmed management had previously identified the deficiencies in relation to chemical restraint including overdue reviews for consent, lack of supportive diagnosis for indications of use, the incomplete Psychotropic register and incomplete behaviour support plans.

The response advised the Psychotropic register has now been completely updated and accurately reflects consumers identified as requiring chemical restrictive practice consents and risk assessments as well as the diagnosis and indications for use. This information was also updated across the high risk, high impact register for the attention of the clinical team. A copy of the updated Psychotropic register was included in the provider response.

Behaviour support plans for all consumers subject to chemical restraint have been completed and are also included in the high risk, high impact register to assist the clinical team.

Dementia Services Australia training for staff on the management of consumers with dementia has been approved and is expected to commence in March 2024. The training will include restrictive practices, behaviour management strategies and understanding the impact of dementia.

A comprehensive training program for registered staff has also been developed which will cover four full days. The training covers such issues as incident reporting and SIRS, care plan reviews, behaviour management, risk assessments, falls management and the clinical governance framework at Wellington Park.

With regards to wound care, two sampled consumers with active wounds said they are consistently attended to in accordance with wound management plans. Monitoring charts are active for use following treatment and at every review, however, progress notes and photographs were not consistently captured in the wound management charts.

The provider response advised this issue has now been addressed with all consumer wounds monitored consistently with current photos and progress entries. The CNCs have instructed registered staff regarding the importance of consistent documentation and the matter has been added to the agenda for the next clinical staff meeting.

In coming to a decision regarding this Requirement, I acknowledge the immediate and ongoing responses by the approved provider to the deficiencies identified by the Assessment Team. However, I also note that some responses are ongoing and I am of the view that it will take some time for the improved processes to become embedded in the regular practice of staff. As a result, I have decided that Requirement 3(3)(a) is currently Not Compliant.

# 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. | Not Compliant |

Findings

**Assessment**:

The Assessment Team report indicated that the service demonstrated effective governance systems in place relating to continuous improvement, financial governance and feedback and complaints.

Opportunities for continuous improvement are identified through consumer and staff meetings, feedback and complaints, and employee suggestions. Areas for continuous improvement have been appropriately identified and actioned. The service’s Plan for Continuous Improvement (PCI) identifies the planned and completed improvement actions in relation to various areas of care and service delivery. In response to deficiencies identified by the Assessment Team, management committed to updating the PCI to track progress and outcomes.

Management advised they are responsible for control of the day-to-day budget for the service, and additional expenditure outside the allocated budget or changes to the budget are referred to the Chief Executive Officer (CEO) for approval. Management described the process needed if additional funds are required to adapt to changing consumer needs and said additional funds were always available to meet these. The Assessment Team did not identify any deficiencies in relation to financial governance systems.

The service demonstrated systems are in place to encourage the provision of consumer feedback and complaints. There was evidence of open disclosure within staff practices and the Assessment Team observed the pathway capturing consumer feedback and complaints and how this positively contributes to improvement initiatives and outcomes. The service maintains a current feedback and complaints policy which includes responsibilities and procedures for managing feedback. The organisation maintains a deadline for complaint resolution of thirty days.

The Assessment Team report identified deficiencies in relation to information management, workforce governance, and regulatory compliance.

Information Management

With regards to information management, medication and incident information is currently captured in the service’s Electronic Care Management Systems (ECMS). The Assessment Team report indicated this system does not have capabilities for reporting or effective management and monitoring of incidents and medication administration, resulting in identified errors in care documentation and information management. For example, a named consumer prescribed time sensitive anticoagulant medication received their doses in an inconsistent way which was not administered at the prescribed times. Doses were recorded as administered up to four hours late. Management advised they believed the errors in administration arise from the ECMS requirement for the medication to be recorded as administered by two registered staff members. Management also advised the service is in the process of obtaining an improved ECMS.

A review of wound charts evidenced inconsistent information regarding wound check frequency and dressings compared to the wound care plan. Wound photographs and progress notes were recorded inconsistently, with some wounds not having photographs taken in over thirty days. Management acknowledged the inability to effectively monitor or manage consumer wounds with the inconsistent recording of clinical information. Some of these issues were identified as being related to problems with the software used for recording wound information.

Consumers with a diagnosis of diabetes did not have care plans located consistently. Critical clinical care information for consumers who experience hypoglycaemic or hyperglycaemic events was not easily accessible by staff, with some information not available at all. Management acknowledged the likelihood of confusion this could cause with staff unfamiliar with these consumers’ needs and the risk of adverse clinical outcomes associated with the management of consumer’s diabetes.

Information pertaining to allied health reviews, such as changes to consumer care requirements are not updated within consumer care plans. For example, updates from the Physiotherapist were recorded in consumers progress notes, but these were not reflected in the consumers mobility plans. The report said management acknowledged ongoing improvements are needed to ensure accuracy of allied health information.

Management advised they maintain a high-risk consumer register to monitor all consumers with high impact and high prevalence risks. A review of this register noted some consumers risk information was inaccurate or out of date. Management was aware of the data inconsistencies and confirmed they were updating the register to provide a centralised data base to monitor consumers clinical risks. Despite management having a plan to remedy the identified deficiency, this was not included in the service’s PCI.

A review of the service’s staff compliance register (which contained information regarding qualifications, registration details and police checks) evidenced it had not been maintained to ensure staff information and qualifications are up to date. Management was aware of this and advised they were acting to remedy the situation. Despite management having a plan to remedy the identified deficiency, this was not included in the services PCI.

The services falls management policy had recently been updated to increase neurological observations from 24 hours to 72 hours post fall. However, the Assessment Team interviewed registered staff members who were unaware of the new requirement to extended neurological observations. Management acknowledged the breakdown in communication regarding policy updates and committed to providing further information to staff in relation to the falls management policy.

Staff confirmed the service had policies and procedures for clinical and personal care however many staff were unfamiliar with the information contained within the policies such as the falls management policy, open disclosure procedure and restrictive practices policy. Some policies were overdue for review and had not been updated to reflect current organisational processes. Despite the service’s identification of deficiencies within policies and procedures, a PCI action had not been created.

While the service demonstrated timely identification of areas for improvement, the service did not maintain a PCI which contained information sharing and appropriate monitoring of improvement actions. Management committed to updating the PCI to include improvement information for monitoring and review by appropriate management personnel.

In responding to the deficiencies identified regarding information management, the approved provider report advised that actions regarding time sensitive medication have been addressed. These actions are outlined in Requirement 3(3)(a) of this Performance report. The response also notes medication administration can be reviewed through the medication charts, while the organisation implements a new electronic medication management system during the next two months.

The response said issues regarding the recording of wound information have now been addressed. The software product provider has explained the correct processes for staff to follow when entering new data and photos. All registered staff and management are to receive training in this process which will facilitate accurate and timely wound management. This issue has been added to the PCI to track progress and improvement across the service.

Diabetes care plans are now in place and consumer diabetic information has been added to the high risk, high impact register managed directly by the CNCs and reviewed monthly as part of clinical indicator analysis.

The provider response disputed the Assessment Team comments regarding Allied Health reviews. The response advised that a review of consumer care documentation has not identified any instances where the information has not been added to the consumer progress notes and updated on mobility plans. The response notes no consumers were specifically identified in the Assessment Team report. I accept the provider response regarding this issue.

The provider advised the consumer high risk register has been updated and completed since the Assessment Team visit.

Improvements in the information collated in the staff compliance register are underway. All staff police checks have been updated and are current. Other aspects of the staff compliance register continue and will be monitored until the process has been completed. The issue has been updated in the service’s PCI to reflect the project’s initiation and progress. A copy of the PCI was provided with the response.

The updated falls management policy has now been issued to all staff to read and has been discussed with registered staff. The recording of neurological observations are monitored daily by the CNCs.

An overall review of and update of all policies within the organisation is being undertaken by the Group Manager. While a matter of priority, this process is expected to take between 3 and 6 months to complete. The ongoing process for policy and procedure reviews has been added to the service’s PCI.

Workforce Governance

The organisation maintains a workforce governance framework to ensure staff are skilled and qualified to provide safe, respectful, and quality care and services to consumers. This includes position descriptions, duty lists and escalation procedures to ensure areas of accountability are upheld by appropriate staff. However, review of the services mandatory online training register evidenced approximately 40% of training modules have been completed by staff. Management advised they were aware of the low compliance rate and would provide staff with a training deadline and place staff on unpaid leave should they fail to meet training requirements.

Interviews revealed staff are overdue for performance appraisals. Staff are scheduled to complete an appraisal every two years, however, the service could not evidence records to support that this had occurred. Management have commenced performance appraisals for staff; however, a number of staff appraisals remain outstanding.

The service does not have a current Infection Prevention and Control (IPC) lead on site and has not had an on-site IPC lead for some time. While there are two registered staff members who have agreed to undertake the course in the future, the service relies on phone contact with an IPC lead from the organisation’s sister site in the event of an infectious outbreak.

The provider response advised the organisation offers paid hours for the completion of mandatory training modules and a general staff meeting will address the matter with staff to ensure compliance is a condition of employment. The issue has been added to the service PCI to track progress and results.

Management has actioned a plan to renew every staff member performance appraisal between February and April 2024 and this work has commenced.

The provider response confirmed the IPC lead position remains vacant. The response stated the service maintains a robust outbreak management plan, senior nursing personnel are experienced with the requirements of infection control and outbreak management and there is an IPC lead available from the service’s sister home less than one hour away.

Regulatory compliance

Management advised legislative changes, industry standards and guidelines are monitored by the organisation through subscriptions to various legislative services and peak bodies including the Commission.

The service maintains a Serious Incident Response Scheme (SIRS) escalation pathway in the event of an incident. While SIRS is part of the services mandatory training schedule, many staff remain overdue for SIRS training completion. Interviews with staff evidenced mixed knowledge surrounding what constitutes a SIRS incident. The Assessment Team were unable to confirm if all appropriate incidents had been reported to SIRS as per legislative requirements. The report indicated limitations of the ECMS and management’s system of reviewing consumer progress notes daily present a risk to the identification and response to incidents which may constitute a SIRS.

Management acknowledged previous incorrect reporting of National Mandatory Quality Indicator Data. During the previous reporting period, the service reported 4% of consumers were subject to restrictive practices, however, the Assessment Team identified approximately 67% of consumers are currently subject to restrictive practices. The service had also reported one percent of consumers were subject to psychotropic medications without a diagnosis of psychosis, however, the correct figure was noted by the Assessment Team to be approximately 37%. Management acknowledged the requirement to accurately report this data in line with its regulatory obligations.

Information kept on the services restrictive practices register was incorrect and did not accurately reflect the last or next review date of consumers chemical restraint. Management advised they were aware of this issue and had already established an item in the service’s PCI to review all consumers subject to chemical restraint however, this was yet to be completed at the time of the Assessment Contact.

The approved provider response disputed that the service’s system for monitoring incidents created a risk of unreported SIRS. The response stated the clinical management team complete a comprehensive clinical review of all incidents and that effective and prompt actions are taken to manage possible consumer impact.

The response acknowledged the Assessment Team comments regarding inaccurate reporting through the National Quality Indicator Report, while advising the percentage figures might be different, and confirmed the service is aware of the requirement to report information in an honest and true manner.

The review of care documentation for consumers subject to restrictive practices has been reviewed and updated and all consumer reviews for chemical restraint have now been completed.

Following consideration of the above information, I would like to acknowledge and commend the immediate and comprehensive actions being undertaken by the approved provider to address the identified deficiencies in Requirement 8(3)(c). The detailed response to the Assessment Team report also indicates a strong commitment to address issues related to this Requirement. However, there are numerous issues that were identified by the Assessment Team and some of the actions necessary to address the identified deficiencies will require time to complete. I note, for example, that staff mandatory training and performance appraisals are yet to be completed and that the updating of policies and procedures will require 3 to 6 months. Therefore, I have decided that Requirement 8(3)(c) is currently Not 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)