Performance

Report

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| Name of service: | Wesley House Aged Care Facility |
| Service address: | 324 Military Road SEMAPHORE PARK SA 5019 |
| Commission ID: | 6072 |
| Approved provider: | UnitingSA Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 29 November 2022 |
| Performance report date: | 13 January 2022 |

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 Wesley House Aged Care Facility (**the service**) has been prepared by R Beaman, 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 15 December 2022; and
* the performance report dated 02 June 2022 for the site audit undertaken from 16 March 2022 to 18 March 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **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.

**Standard 2**

* Requirement 2(3)(a) – ensure the assessment and planning process includes consideration of risks to consumers’ health and well-being to inform the delivery of safe and effective care and services.

**Standard 3**

* Requirement 3(3)(b) – ensure high impact or high prevalence risks to the care of consumers are effectively managed.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |

Findings

The service was found Non-compliant with Requirement (3)(a) in this Standard following a site audit undertaken from 16 March 2022 to 18 March 2022. The service was not able to demonstrate assessment and planning included consideration of risks to consumers’ health and well-being to deliver safe and effective care and services in relation to diabetes, restrictive practices and skin integrity.

The service implemented a number of improvement actions to address the deficits identified, including reviewing all assessment and planning documentation to ensure restrictive practice information was recorded in line with legislative requirements, diabetic management directives were included where appropriate and education to staff around assessment and planning, including diabetes, pain and restrictive practices.

While the service implemented improvement actions, the Assessment Team recommended Requirement 2(3)(a) as not met. The Assessment Team found the service was unable to demonstrate the assessment and planning process was effective in developing behaviour support plans for consumers with changed behaviours and use of restrictive practices to manage behaviours, falls and risk of blood clots in consumers’ urine. The Assessment Team identified three consumers (Consumers A, B and C) where assessment and planning was not effective and provided the following information and evidence relevant to their recommendation.

For Consumer A, the assessment and planning process was not used to develop an effective behaviour support plan to inform behaviour management strategies. The behaviour assessment completed for Consumer A did not capture individualised strategies to manage adverse behaviours to trial prior to administration of psychotropic medication and consent for use of chemical restraint was obtained directly from Consumer A. There was no information in care planning to inform staff practice using this as a last resort.

For Consumer B, the service did not use assessment and planning to identify the risk of blood clots in Consumer B’s urine, or strategies to prevent further risks of blood clots, or to guide staff to monitor Consumer B and escalate to clinical staff. Consumer B has a high falls risk and while staff were able to describe the strategies used to mitigate this risk, they were not captured in Consumer B’s care plan.

For Consumer C, the service did not have assessment directives in relation to a left heel wound in place, with no documentation in relation to the wound and staff did not identify there was a current wound that required interventions.

The provider’s response acknowledges the findings in the Assessment Team’s report and included actions they have implemented immediately following the Assessment Contact visit to address the deficits identified, including for Consumer B, a review and update of the care plan to include information and treatment in relation to the health condition contributing to blood clots and blood in urine along with a falls safety assessment to identify strategies to manage the risk of falls. The provider included evidence for Consumer B to show the improvement actions had been undertaken in relation to care documentation which included strategies to manage risk of falls, such as the placement of a sensor beam to alert staff when movement was made an minimise further falls.

For Consumer C, the provider asserts they have taken immediate actions to address the deficits identified in wound care and management of pressure injuries, including commencement of a new wound treatment plan for the wound identified on the day of the Assessment Contact visit that had not been managed appropriately, along with an incident report and escalation to the Commission as a Serious Incident Response Scheme report.

In relation to Consumer A, the provider asserts the service’s management team were not aware there were issues in obtaining the behaviour support plan and included in their response the full behaviour support plan for Consumer A. However, the provider also acknowledges the Assessment Team’s findings in relation to the information in the support plan lacking in relation to restrictive practices and have provided additional evidence to show that has been updated.

In coming to my decision, I have considered the evidence presented in the Assessment Team’s report along with the information and evidence presented in the provider’s response. I find that while the provider has implemented a number of improvement actions to address the deficits identified in the Assessment Team’s report, these have been actioned post the Assessment Contact visit as a result of the information identified in the Assessment Team’s report and I encourage the provider to continue with the implementation of improvement actions. However, at the time of the visit the service did not have an effective assessment and planning system that consistently considered the risks associated with the health and well-being of consumers to inform the delivery of safe and quality care and services.

Accordingly, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers Non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

Findings

The service was found Non-compliant with Requirement (3)(b) in this Standard following a site audit undertaken from 16 March 2022 to 18 March 2022. The service was not able to demonstrate it had effective strategies in place to manage and mitigate high impact or high prevalence risks to consumer care, including the risk of pressure injuries and wound management.

The service implemented a number of improvement actions to address the deficits identified, including undertaking regular wound audits and further education to staff around skin integrity and wound management.

While the service implemented the improvement actions the Assessment Team recommended Requirement 3(3)(b) as not met. The Assessment Team found the service was unable to demonstrate it effectively manages high impact or high prevalence risks with consumers’ care in relation to restrictive practices, specifically chemical restraint, wound care management and monitoring consumers’ blood pressure where readings are low. The Assessment Team provided the following evidence and information relevant to recommendation.

The Assessment Team identified the service could not demonstrate the use of restrictive practices in the form of chemical restraint was used as a last resort or in line with directives for Consumer A. Over a one month period between October 2022 and November 2022, Consumer A was administered 2 psychotropic medications to manage changed behaviours, including agitation and crying. One medication was administered on 19 of 22 occasions for behaviour management and on almost half of those occasions there was no evidence it was administered as a last resort.

For Consumer A, clinical staff did not consider pain as a trigger of adverse behaviours and there was no effective pain assessment conducted. On 10 of 22 occasions in the same four week period, pain relief was administered within 2 hours of the psychotropic medication being administered to manage behaviours, including crying and agitation.

Consumer B is assessed as a high falls risk and following a fall on 28 November 2022, low blood pressure was indicated during neurological observations. While clinical staff undertook the observations as per the organisation’s policy, there was a delay of more than 12 hours for further blood pressure readings despite the low reading previously taken and staff did not monitor Consumer B for further symptoms of low blood pressure following the fall.

Consumer C provided feedback about a wound dressing to their left heel and confirmed it had not been regularly attended to. There was no incident form or wound chart, dressings had not been attended to, checked or changed for four days and clinical staff confirmed they were not aware of the wound. There was no information documented on Consumer B’s care record to guide staff to provide wound care, the directives for wound care or that there was a wound on Consumer B’s left heel.

The provider’s response acknowledges the deficits in relation to Consumer C’s wound care. In their response, the provider asserts and provided additional evidence that shows after further investigation Consumer C was identified as having a previous wound which is recorded as being resolved on 17 November 2022. The provider acknowledges the wound observed and identified during the Assessment Contact visit was missed and acknowledged the deficits in care, stating an incident form had been completed and the incident reported as part of the Serious Incident Response Scheme and further education has been provided to staff around wound care. I acknowledge the information presented in the provider’s response and have considered evidence presented in Standard 2 Requirement (3)(a), including for Consumer C that the wound had not been identified by staff, clinical staff did not have knowledge of the wound and there was no wound care plan in place with directives to guide staff practice.

In relation to Consumer B, the provider in their response refutes the findings in the Assessment Team’s report that care delivery was delayed to Consumer B post fall when they register a low blood pressure reading. The provider acknowledges the information relied upon by the Assessment Team was incorrect as the progress note shows the low blood pressure reading taken at 9:25am on the 28 November 2022 was an transposition error and has provided the neurological observations chart that shows the reading was taken at 9:39pm on 28 November 2022 showing there was not a delay of more than 12 hours in care delivery and response to the low reading. I acknowledge the information provided for Consumer B and find in this instance, an error was made in the timing of the low blood pressure reading and there was no delay in care provision.

In relation to Consumer A, the provider refutes information presented in the Assessment Team’s report in relation to the use of psychotropic medication for pain and behaviour management. The provider asserts staff have documented alternative non-pharmacological strategies used for both pain relief and when medication is administered to manage agitation. The provider included additional evidence, including progress notes from 28 October 2022 and 29 November 2022 in support of this claim. I have reviewed the additional information presented in the provider’s response and note where one of the psychotropic medications is administered to Consumer A it is in response to adverse behaviours, including agitation and crying, staff did not always record non-pharmacological strategies have been trialled prior to administration and the use of the medication is not always evaluated. I acknowledge that while information provided in the response shows Consumer A on some occasions refuses other strategies and requests medication administration, staff do not always record alternative strategies are trialled or the effectiveness of administering the medication.

I acknowledge that pain assessments were completed on 16 to 18 October 2022 and 28 to 30 October 2022 and while I acknowledge the provider’s assertion that the first pain assessment records pain management is effective the further assessment shows administration of opioid pain relief over the 15 day prior to the assessment (which includes the timeframe of the previous pain assessment) was administered on 20 occasions with progress notes recording Consumer A was screaming, yelling or complaining of pain on multiple occasions and a query of drug of dependency (DDA) in the same progress note dated 31 October 2022.

In coming to my decision, I have considered evidence presented in the provider’s response and Assessment Team’s report, including evidence presented in Standard 2 Requirement (3)(a) where for Consumer A, the behaviour support plan was lacking information in relation to restrictive practices, including chemical restraint. Whilst the provider has implemented immediate changes through review and update of the support plan for Consumer A at the time of the visit, staff were not consistently showing administration of psychotropic medication in an as required dose at very regular intervals was done as a last resort or for the least amount of time.

Accordingly, I find Requirement (3)(b) in Standard 3 Personal care and clinical care Non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service was found Non-compliant with Requirement (3)(f) in this Standard following a site audit undertaken from 16 March 2022 to 18 March 2022. The service was not able to demonstrate that meals provided were of suitable quality.

The service implemented a range of actions to address the identified deficits, including reviewing catering menus in consultation with consumers, representatives and dieticians, the creation of seasonal menus operating on a four weekly rotation and undertaking of internal catering audits to identify issues with temperature control.

The Assessment Team recommended the service is met in this Requirement. Sampled consumers confirmed they were satisfied with meals and the dining experience. Consumers confirmed they were happy with the variety, quality and quantity of meals provided and they had noticed the improvements to the meals provided over recent months.

Documentation showed where feedback was provided to staff, management or via the feedback system those were actioned with improvements implemented for a positive outcome for consumers.

Accordingly, I am satisfied Requirement (3)(f) in Standard 4 Services and supports for daily living is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found Non-compliant with Requirement (3)(d) in this Standard following a site audit undertaken from 16 March 2022 to 18 March 2022. The service was not able to demonstrate it responded appropriately to feedback and complaints, specifically in relation to food, to improve the quality of care and services.

The service has implemented the following actions to address the identified deficits, including analysis of all feedback by serviced management on a monthly basis to identify trends and continuous improvement opportunities, the re-establishment of the service’s food focus group to identify areas of improvement through consumer feedback and toolbox training provided to staff in relation to responding to and recording feedback and complaints received from consumers and/or representatives.

Consumers confirmed they were satisfied their feedback, including complaints are managed appropriately and information they provide is used to improve care and services. Consumers sampled who had previously provided feedback about dissatisfaction with food confirmed they had seen improvements in meal service and their complaints were used to do this.

Staff demonstrated understanding of the service’s feedback and complaints system and provided examples of how they respond when consumers provide feedback or make a complaint to drive improvements to care and services.

Documentation showed feedback and complaints are recorded on a register and opportunities for improvement have been identified and implemented using the feedback provided by consumers via the feedback and complaints system, including for food and other lifestyle services.

Accordingly, I find Requirement (3)(d) in Standard 6 Feedback and complaints 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)