Copperhouse Court Hostel

Performance Report

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**Commission ID:** 6155

**Provider name:** Whyalla Aged Care Inc (t/a Kindred Living)

**Assessment Contact - Desk date:** 27 March 2021

**Date of Performance Report:** 8 June 2021

# Publication of report

This Performance Report **may be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| --- | --- |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Desk; the Assessment Contact - Desk report was informed by review of documents and interviews with a representative, staff and management
* the provider’s response to the Assessment Contact - Desk report received 19 April 2021
* the service was found Non-compliant with Standard 3 Requirement (3)(b) and Standard 7 Requirement (3)(a) following an Assessment Contact – Site conducted 23 March 2021.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Assessment Team assessed Requirement (3)(d) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The Assessment Team have recommended Requirement (3)(d) not met. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 8 Requirement (3)(d) and find the service Non-compliant with Requirement (3)(d). The reasons for the finding are detailed in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) Non-compliant

*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.*

The Assessment Team were not satisfied the service demonstrated effective risk management system and practices. Issues identified related to one consumer who had ongoing risk of exit seeking and attempts to leave the secure memory support unit. The consumer went missing from the service two days prior to the Assessment Contact and was missing for a period of three and a half days. The Assessment Team’s report provided the following evidence:

* The consumer had four incidents of absconding from the service in 2020. The outside gate leading from the service’s outdoor area to the street was found to not be locked on each occasion. Appropriate or effective actions were not implemented in response to the incidents.
* All staff interviewed confirmed there was no written or recorded directive or procedure for checking the outside gates. Staff sampled described inconsistent processes for checking the gate.
* Staff and the consumer’s representative confirmed the consumer’s exit seeking behaviours and attempts to leave the facility occur multiple times each day. They stated no strategies are effective in distracting the consumer for a sustained period, preventing behaviours or reducing severity of behaviours. The behaviours have been ongoing since the consumer entered the service.
* Incidents reports have not been completed in response to these behaviours to inform or identify the ongoing nature or increased risk.
* An effective review of the behaviours, including review of current management strategies has not been undertaken.
* Management stated no strategies, other than a sensor mat, half hourly sighting checks, fixing the gate lock and asking staff to check the gate have been considered.
* The new Facility manager and Clinical nurse were not aware or informed of the consumer’s risk of absconding or ongoing daily exit-seeking behaviours.
* Five days prior to the Assessment Contact, new management identified the consumer had behaviours of repeatedly trying to exit the building. However, review of current management strategies or implementation of additional strategies to manage the risk were not undertaken.
* An absconding record, initiated two days prior to the Assessment Contact, included 11 occasions over a six hour period where the consumer exhibited exit seeking behaviour. Staff had not recorded strategies used in response to the behaviour and management confirmed no directives had been provided to staff relating to actions to take in response to the behaviour.
* Appropriate and timely actions were not taken in response to the consumer being identified as missing, including no immediate search of surrounding streets, review and contacting of visitors to the service recorded on the visitor sign in register or formal interview of staff working in the memory support unit.
* Police were notified within half an hour of the consumer being reported missing. However, they did not commence an investigation or attend the service until several hours after the consumer was reported missing.
* Review of swipe card records, and visitor records occurred two days following the incident.
* There were inconsistencies in the description of what the consumer was wearing when they went missing. Management confirmed the service does not have a process to record this daily for consumers at risk of absconding.
* The incident report does not contain detailed records of what occurred and what investigations, interviews with staff and actions occurred and when in response to the incident.
* Management confirmed formal records had not been completed or interviews and investigations undertaken documented.
* Incident, risk data and information is not effectively recorded, reported, communicated, analysed or used to identify ongoing or new risks to inform appropriate actions, evaluate effectiveness of risk management systems or implement improvements.
* The service does not have an effective system or policy relating to risks associated with consumers trying to leave the facility.
* The new Facility manager had not been orientated to or read the absconding policy.

The provider agrees with the Assessment Team’s recommendation of not met. The provider’s response included a Plan for continuous improvement (the Plan) directly addressing the issues identified in the Assessment Team’s report. The Plan includes planned actions, planned completion dates and outcomes. Planned and/or completed actions include, but are not limited to:

* Met with the consumer’s representative to discuss planned strategies being implemented.
* Completed reviews of all consumers who display risk of exit-seeking behaviours. Two consumers have been identified and actions implemented.
* Alarm bracelets have been implemented for two consumers to monitor movement.
* Two consumers have been reviewed by Dementia Support Australia and recommendations have been actioned.
* Developed a resident profile priority list, prioritising consumers at high risk.
* Implemented security changes, including upgrade of the gate in the memory support unit garden, plan to install closed circuit television cameras along the perimeter fence and installed additional DECT phones.
* Implemented consumer sighting charts and the need to record clothing worn.
* Reviewed the Missing resident/Absconding policy to include clearer directions to guide staff.

I acknowledge the provider’s response and actions planned and/or implemented to address the deficiencies identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, the service’s risk management systems and practices were not effective in identifying and minimising the risks of a consumer with known exit-seeking and absconding behaviours.

In coming to my finding, I have placed weight on information in the Assessment Team’s report demonstrating the consumer’s exit seeking behaviours and risk of absconding were known by the service, had been ongoing since the consumer entered the service and occurred multiple times each day. Whilst staff indicated no strategies were effective in minimising the consumer’s behaviour, management strategies had not been reviewed and/or new strategies implemented to mitigate the consumer’s risk of absconding.

I have also considered that actions taken immediately following reports of the consumer being missing from the service were not appropriate or timely. A search of the area and streets around the service was not immediately undertaken in an attempt to locate the consumer. A search was not initiated until the Police attended the service approximately six hours after the consumer was reported as missing. Additionally, further investigative processes were also insufficient; staff on duty were not formally interviewed in relation to the incident and review of swipe card and visitor records did not occur until two days after the incident.

For the reasons detailed above, I find Whyalla Aged Care Inc (t/a Kindred Living), in relation to Copperhouse Court Hostel, Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

# 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 provider’s response included a Plan for continuous improvement outlining actions the service have or plan to implement which directly address the issues identified by the Assessment Team in the relevant Requirements.

**In relation to Standard 8 Requirement (3)(d)**

* Ensure staff have the skills and knowledge to:
* identify and appropriately document episodes and/or incidents of challenging behaviours.
* in response to challenging behaviours, review and/or develop appropriate management strategies to reduce the incidence of behaviours and risk to the consumer.
* monitor the incidence of challenging behaviours, implement appropriate monitoring, reassessment and review processes and initiate referrals where additional support is required.
* Review clinical incident data trending and analysis processes to ensure consumers at risk or who are involved in ongoing incidents are identified and strategies to mitigate risks reviewed and/or developed.
* Review incident review processes to ensure incidents are adequately investigated and appropriate actions implemented to prevent and monitor associated risks.
* Ensure policies, procedures and guidelines in relation to management of missing consumers/absconding, are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to missing consumers/absconding.