Eldercare Allambi

Performance Report

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**Commission ID:** 6183

**Provider name:** Eldercare Inc

**Assessment Contact - Site date:** 2 August 2021

**Date of Performance Report:** 27 September 2021

# Publication of report

This Performance Report **will 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 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(g) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | 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 - 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 Contact - Site report received 25 August 2021

the Performance Report dated 19 April 2021 for the Assessment Contact conducted 11 February 2021.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

The Assessment Team assessed Requirements (3)(b), (3)(d) and (3)(g) in this Standard at the Assessment Contact and recommended Requirements (3)(b) as not met and Requirements (3)(d) and (3)(g) as met. In relation to Requirement (3)(b), the Assessment Team found the service unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to management of swallowing deficits, falls, medication, diabetes and responsive behaviours. The Approved Provider submitted a response which disagreed with the Assessment Team’s findings in relation to Requirement (3)(b) and addressed the evidence contained in the Assessment Team’s report. In coming to my finding, I considered and accepted the service response in relation to medication and diabetes management. However, the service did not demonstrate effective management of high impact or high prevalence risks in relation to swallowing deficits, falls and management of responsive behaviours.

In relation to Requirement (3)(d), The Assessment Team found the service able to demonstrate clinical deterioration in consumers was identified and responded to in a timely manner in relation to two consumers.

The service was found Non-compliant with Requirement (3)(g) following an Assessment Contact conducted on 11 February 2021. Specifically, the service was unable to demonstrate minimisation of infection related risks through standard and transmission based precautions as use and storage of personal protective equipment (PPE) was not appropriate, and the service did not manage consumers with respiratory infections effectively to reduce the risk of transmission. In relation to Requirement (3)(g), the Assessment Team has recommended this Requirement as met, as the service demonstrated appropriate use and storage of PPE, and improved staff knowledge and practices related to the minimisation of infection related risks.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the Approved Provider’s response to come to a view of compliance and find the service Non-compliant with Standard 3 Requirement (3)(b) and Compliant with Requirements (3)(d) and (3)(g).

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team was not satisfied that the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer in relation to management of swallowing deficits, falls, medication, diabetes and the management of behavioural responses for one consumer.

The Assessment Team found that for one consumer, (Consumer A), who has a diagnosis of Parkinson’s disease, the service was unable to demonstrate effective management of risks associated with swallowing difficulties and falls. Specifically, the Assessment Team found that Consumer A was provided with the incorrect textured diet which resulted in an episode of aspiration. The Assessment Team provided the following information relevant to my finding:

* The Assessment Team found that on 22 July 2021, Consumer A experienced an episode of coughing, vomiting, excessive secretion and low oxygen saturation levels following lunch. The Assessment Team found that the Consumer was not reviewed by their General Practitioner (GP) until later in the day who recommended transfer to hospital where the consumer was diagnosed with aspiration pneumonia.
* The Assessment Team found that Consumer A was provided with the wrong textured diet which induced the incident (choking) on 22 July 2021 as:
* Progress notes on 8 July 2021 indicated Consumer A was being provided a normal texture diet, and this was changed to an easy to chew texture diet following difficulty swallowing, however the Consumer’s nutritional care plan dated 7 July 2021 stated the Consumer required a minced moist textured diet.
* The Assessment Team found that no assessment or monitoring was documented between 8 and 22 July 2021 following the dietary modification from normal texture to easy to chew texture, and a referral to a speech pathologist did not occur.
* The Assessment Team found that Consumer A was reviewed by a speech pathologist on 22 July 2021 (following the incident) who recommended a texture modified (mince moist) diet.
* The Assessment Team interviewed care staff in relation to the care of Consumer A, and the care staff were able describe how they assisted the consumer to eat, observed for any signs of difficulty swallowing and understood their role in escalating changes to clinical staff. The care staff were able to explain what signs and symptoms they monitored for, including (but not limited to) food pocketed in the mouth.
* The Assessment Team interviewed a kitchen staff member who demonstrated understanding of Consumer A’s dietary texture requirements at the time of the Assessment Contact, being minced moist, in alignment with the Consumer’s food chart.

In relation to falls management for Consumer A, the Assessment Team found the consumer experienced 13 falls between May and July 2021 and contributing factors for the falls had not been identified such that falls prevention and injury minimisation strategies had not been planned and implemented to mitigate the risk of further falls. The Assessment Team provided the following information relevant to my finding:

* The Assessment Team interviewed the consumer’s representative who stated that Consumer A has not been mobile or walked for at least four weeks, and that the falls occur when the consumer is trying to get up and there is insufficient staff in the memory support unit to supervise the consumer and prevent falls when they try to get up.
* The Assessment Team interviewed care staff who stated that they are not always available to observe Consumer A which results in falls, as they are too busy attending to other consumers.
* The Assessment Team interviewed care and clinical staff in relation to the care of Consumer A, and the staff stated that when the consumer needs to go to the toilet, they can experience irritability and aggressive responsive behaviours, and if staff are not around, the consumer will attempt to get up and then fall.
* The Assessment Team reviewed the file for Consumer A and found:
* Consumer A’s FRAT (Falls Risk Assessment Tool) dated 8 June 2021 indicates the consumer is at high risk of falling.
* The Consumer’s GP has undertaken medication reviews and review of the consumer’s postural hypotension in April 2021, following an evaluation of the consumer’s falls.
* On 17 June 2021, a physiotherapy review recommended sourcing a suitable chair for Consumer A.
* On 25 June 2021, Consumer A was reviewed by an occupational therapist.
* Following each fall, the service demonstrated appropriate injury assessment, neurological and vital observations, notification of representatives and the GP. However, the Assessment Team found that Consumer A had not been reviewed by a physiotherapist following each fall in line with the service’s protocol.

In relation to medication management, the Assessment Team found that the service was unable to demonstrate timely medication administration for one consumer who experiences anxiety and breathlessness when their inhaler medication is administered late. The Assessment Team interviewed clinical staff who are aware of which consumers require time sensitive medicines, and consumers who become anxious if their medicines are not administered on time and they prioritise those consumers. Staff stated there are occasions when medicines are administered later, due to clinical incidents.

In relation to behaviour management, the Assessment Team found the service unable to demonstrate effective management of the behavioural responses for one consumer (Consumer B). The consumer has a diagnosis of dementia and displays unwanted affection (such as kissing) towards other consumers. Specifically, the service had not implemented strategies to manage the consumer’s behavioural responses. The Assessment Team provided the following information relevant to my finding:

* The Assessment Team discussed the care of Consumer B with management who stated that the consumer had been reviewed by Dementia Support Australia (DSA), however, recommendations from the review have not yet been implemented.
* The Assessment Team viewed the DSA report of the review, which occurred on 28 January 2021 which recommended scheduled activities for Consumer B.
* The Assessment Team interviewed clinical and care staff who stated that care staff are expected to provide diversional therapy for all consumers in that area, however there are no planned activities for Consumer B, as there is no time, due to the challenging behavioural responses exhibited by most consumers in that wing.
* The Assessment Team observed that there were no activities or stimulation for consumers in Consumer B’s area on the day of the Assessment Contact.
* Clinical and care staff stated that not all incidents related to the consumer’s behavioural responses towards other consumers is reported. The Assessment Team identified one incident was reported during July 2021, however eight occasions documented in the progress notes between 8 and 28 July 2021 where Consumer B has displayed affectionate advances towards other consumers, with no corresponding incident report.
* The Assessment Team reviewed six incident reports where Consumer B exhibited unwanted affection to other consumers between 23 January 2021 and 7 July 2021, including an incident on 6 March 2021 where Consumer B continued to follow a consumer and attempt to grab them despite staff intervention. The Assessment team identified that following the incidents, the service staff considered pain and unidentified pathology, (such as a urinary tract infection) as contributory factors, and implemented increased visual monitoring. On three occasions, Consumer B was transferred to another memory support unit, and twice transferred to hospital for assessment.
* At the Assessment Contact, the Assessment Team observed Consumer B to be sitting holding hands with another consumer on three occasions and staff did not intervene.

In relation to diabetes management, the Assessment Team found that the service was unable to demonstrate effective management of diabetes for two consumers. Specifically, a consumer’s blood glucose levels were not consistently monitored according to their diabetes management plans, and for another consumer, diabetes management instructions were not clear, consistent or current. The Assessment Team provided the following information relevant to my finding:

* The Assessment Team interviewed Consumer C who expressed concern that staff were not managing their diabetes well, and due to their concerns, they contacted their endocrinologist to write to the service to allow them to manage their own diabetes at the service, which occurred. Further, Consumer C expressed that on three occasions when they notified staff they were experiencing signs and symptoms of a low blood glucose level, staff did not attend to monitor the level. Consumer C stated that they usually have their BGL monitored at 2:00 am and requires intervention if the level is low.
* A diabetes management plan for Consumer C was not completed until 23 days after they were admitted to the service.
* The Assessment Team found that staff do not have a consistent location for documenting blood glucose levels (BGLs) as staff utilised progress notes, electronic BGL chart and medication charts. Further, there are gaps in the records, showing that Consumer C’s BGL is not always monitored according to the diabetes management plan, for example, at 2:00 am. The monitoring occurred late (between 3:00 and 4:14 am) on three occasions and did not occur on two occasions.
* The Assessment Team found that for Consumer D, who has a diagnosis of type II diabetes mellitus and requires insulin to manage their diabetes, the diabetes management plan was an outdated plan and inconsistent with the prescribed insulin prescription regime. The Assessment Team discussed this with the service, who identified that there was a current diabetes management plan which had been filed in error. However, the Assessment Team identified that the current plan had not been updated in over 12 months.
* The Assessment Team observed that Consumer D’s insulin prescription on the medication chart was crumpled, torn and faded.

The Approved Provider submitted a response to the Assessment Team’s report, and did not agree with the Assessment Team’s findings in relation to Standard 3 Requirement (3)(b). The Approved Provider stated that the evidence provided in the report was not factual, contradictory and insufficient to demonstrate that high impact and high prevalence risks are not being effectively managed at the service. The provider’s response included (but was not limited to):

In relation to the management of Consumer A’s dietary risks and falls, the Approved Provider responded with the following information relevant to my finding:

* Consumer A was not provided with the incorrect dietary texture on 22 July 2021, and the evidence in the Assessment Team’s report was incorrect. A diet assessment for Consumer A dated 8 July 2021 was provided which documents the change to normal diet easy to chew texture on this date. The provider considered this was appropriate in response to the consumer’s difficulty swallowing with a normal textured normal diet. The Assessment Team evidence that Consumer A was required to have a mince moist texture diet at the time of the incident, based on a hard copy nutritional care plan dated 7 July 2021 was incorrect. The consumer was assessed as requiring a mince moist textured diet following the incident on 22 July 201, (as reported in the Assessment Team’s report), not on 7 July 2021 (prior to the incident). There was no Nutrition and Hydration Care plan dated 7 July 2021 as asserted by the Assessment Team.
* Provided progress note evidence for 22 July 2021, which demonstrated Consumer A was reviewed by their GP in a timely manner (within 30 minutes) following the incident on 22 July 2021 and Consumer A was transferred to hospital within 30 minutes of the GP review.
* Provided a Nutrition and Hydration care plan dated 22 July 2021 which documents normal diet of minced moist texture, mild thickened fluids and instructions to staff including (but not limited to), supervision, reporting changes and ensuring Consumer A is alert and upright (90 degrees) for all oral intake.
* Considered that there were no further concerns with Consumer A’s swallowing following the dietary texture change on 8 July 2021, so there was no indication for a review by a speech therapist at that stage.
* Considered that a speech therapist review occurred at an appropriate time for Consumer A, following the incident on 22 July 2021.
* Consumer A did not have a choking episode, and the consumer did not vomit, although this was documented as such by the GP on 22 July 2021. The incident was an episode of excessive phlegm production.
* The Assessment Team report stated that Consumer A experienced 13 falls between May and July 2021, however this is incorrect. Consumer A fell eight times within that time period.
* Provided progress note report of an evaluation of Consumer A’s falls (5) prior to 4 May 2021 which demonstrates analysis of the falls, consideration of triggers, and subsequent falls prevention and injury minimisation strategies.
* The statement made by the Assessment Team, that Consumer A had not been referred to a physiotherapist following each fall in alignment with the service procedure is incorrect. The falls management procedure (provided) states referral to allied health professionals (including physiotherapist) occurs when clinically indicated, following the falls risk assessment and review of the fall that occurs after every fall.
* Considers that the area where Consumer A resides has the highest number of staff at Allambi, and stated that call bell data for the area which demonstrates timely response times, being on average 1 minute 23 seconds.
* A continence assessment was undertaken on 9 April 2021, which identified that the need to void was not necessarily a trigger for falls as the consumer is not able to recognise the need to void. In addition, staff adhere to the scheduled toileting times.

In relation to medication management, the Approved Provider responded with the following information relevant to my finding:

* The Assessment Team report identified staff knowledge of consumers who require time sensitive medicines, and consumers who experience anxiety when medicines are not administered on time. The consumer’s medicine (preventative inhaler) is not time sensitive, and staff are aware of the consumer’s needs and preferences in relation to the consumer’s medicine administration. Further, the Assessment Team report demonstrated that staff at the service have the ability to prioritise clinical activities when required. This evidence supports effective medication management.

In relation to the management of Consumer B’s behavioural responses, the service disagreed that they have not implemented strategies to minimise the consumer’s responsive behaviours and provided the following information relevant to my finding:

* Provided a copy of the Dementia Service Australia (DSA) report dated 4 February 2021 and stated that relevant and reasonable actions from the report were implemented.
* Consumer B was reviewed by a Residential Outreach Team on 10 March 2021 which agreed with the DSA report. The service provided a copy of the outreach team report, which noted that it is easy to misconstrue comfort seeking behaviour with sexual disinhibition, and it is a human need to have physical touch and comfort, and this needs to be facilitated in a way that is safe and therapeutic.
* Responded to the observations made by the Assessment Team in relation to the Consumer holding hands with another consumer without staff intervention. The service explained Consumer B has developed a consensual companionship with this consumer, and the representatives of both consumers have been consulted regarding the nature and frequency of the physical contact and are happy for this to occur. As such, this is not inappropriate behaviour, staff do not prevent the holding of hands or report as an incident. Allambi considers that each consumer should be respected to have the choice to live the life they want with dignity, and this includes consumers with dementia, and their needs and rights to have companionship and friendship.
* Management did not advise the Assessment Team that actions from the DSA report have not been implemented. When the review was completed, relevant and reasonable actions from the review were implemented.
* Disagreed that there are no planned activities for Consumer B and provided information related to the planned activities for consumers.
* Lifestyle staff support daily activities including weekends.
* Clinical leader and/or the enrolled nurse regularly take the lead in ensuring/facilitating the activities program is followed
* Baker MSU consumers are regularly taken to the adjoining MSU to participate in activities with their dedicated lifestyle staff member.
* Volunteers also provide support in Baker MSU.

In relation to diabetes management for two consumers, the Approved Provider provided the following information relevant to my finding:

* Allambi has worked with Consumer C’s endocrinologist and GP to support the consumer’s independence and autonomy in managing their diabetes.
* At each instance where a low BGL has been recorded, staff have intervened appropriately. Identified that there was only one occasion were a BLG was not recorded at 2:00am, on 9 July 2021, and this was due to the consumer asking to not be disturbed overnight.
* Acknowledges that clinicians are recording BGLs in more than one location, however this is due the service policy that staff record BGLs in the BGL chart and the preference of two medical officers that BGLs are recorded on the medication chart.
* Agreed that Consumer C’s diabetes management plan was not completed until 17 June 2021, due to complexities in relation to the consumer’s diabetes management and coordination with the endocrinologist. The GP modified the diabetes management regime on three occasions between 3 and 17 June 2021. The management plan has required five more reviews including consultation with the endocrinologist to support the consumer’s independence and symptomology.
* Agreed that Consumer D’s medication chart is torn, however this does not impact the readability of the chart which is demonstrated by the fact that the Assessment Team transcribed the insulin prescriptions correctly into the report.
* The diabetes management plan for Consumer D was dated 21 May 2020, and therefore was two months overdue at the time of the Assessment Contact due to medical officer leave, not 12 months overdue, as stated by the Assessment Team. This information was included in the Assessment Team report. The diabetes management plan dated 21 May 2020 was not contrary to the consumer’s medication chart, and acknowledges that it had been filed in error.
* Following the Assessment Contact, the service audited all records for consumers with diabetes, and identified that all had a current and correct diabetes management plan in place.

In coming to my finding, I have considered the evidence and information provided in the Assessment Team’s report, the Approved Provider’s response and the evidence and information in support of their response.

In relation to the management of Consumer A’s dietary risks, I agree with the service and consider that there is no evidence that Consumer A was provided the incorrect textured diet in relation to the incident on 22 July 2021. I have considered that initially, the service took appropriate action when the Consumer experienced difficulty swallowing on 8 July 2021 and changed the consumer’s dietary texture to ‘easy to chew’, and this texture aligned with International Dysphagia Diet Standardisation Initiative (IDDSI). However, I consider that following this texture change by staff, the service did not demonstrate effective management of Consumer A’s risk, as the service did not consider referral to a speech therapist to assess the consumer for dysphagia and suitability of the textural change. I have considered the service response which states that there were no concerns regarding Consumer A’s swallowing following the texture change on 8 July 2021. However, best practice recommends that when swallowing problems are suspected or occur, (such as for Consumer A on 8 July 2021) a speech pathologist should assess swallowing function, who will recommend the appropriate level of food and fluid texture. While I acknowledge the provider’s assertion that there were no concerns regarding Consumer A’s swallowing following the texture change on 8 July 2021, I have also placed weight on the Assessment Team’s evidence that no documentation of any ongoing monitoring occurred following the dietary texture change such that this could be determined and ongoing care needs met. As such, I consider that the service did not effectively manage the risks related to swallowing for Consumer A.

In relation to Consumer A’s falls management, I acknowledge that not all falls can be prevented, and Consumer A’s diagnoses of Parkinson’s disease and dementia impacted on their risk of falling. For example, fluctuating and highly variable mobility, lack of insight into their safety needs or requirement for mobility aids, impulsivity in attempting to self-mobilise and postural hypotension. I have considered the evidence provided by the service, which demonstrates multidisciplinary falls risk management, including medical review of medicines and postural hypotension. Further, I have reviewed the service falls analysis and evaluation of all falls (5) occurring prior to 5 May 2021, which demonstrated consideration of pain, continence, ongoing cognitive and functional decline, nutrition, hydration, skin assessments, emotional needs and the location and context of the five falls being analysed. Falls occurred due to Consumer A attempting to stand/mobilise without a mobility aid, or mobilising too quickly. As documented in the Assessment Team report, staff at the service are aware of consumer’s who are prescribed time sensitive medicines. Consumers with a diagnosis of Parkinson’s disease often have time sensitive medicines prescribed. I consider that the information indicates that the service identified contributing factors to Consumer A’s risk of falling and planned appropriate strategies to mitigate the risk of falling. However, in coming to my finding, I have placed weight on staff and representative interviews which indicated that the service is unable to effectively implement falls minimisation strategies (monitoring) of Consumer A to intervene in a timely manner when they attempt to stand, due to insufficient staffing to facilitate the falls prevention strategy. In coming to this finding, I acknowledge, that not all falls can be prevented, and Consumer A may still fall even with timely staff intervention. However, the service has not demonstrated effective management of Consumer A’s falls minimisation strategies to minimise the risk of falls and injury from falls.

In relation to medication management, I have accepted the service response, and consider that information in the Assessment Team report indicated that staff demonstrated appropriate knowledge of consumers with a prescription for time sensitive medicines, and consumers who experience anxiety when medicines are not administered on time. In coming to my finding, I have considered the importance of clinical staff being able to prioritise workload. I consider that the staff at the service demonstrated awareness of consumer needs and preferences, including those that may experience anxiety when their non-time sensitive, non-high risk medicines are not administered at the time prescribed. I considered that while staff aim to facilitate the consumer’s needs and preferences, there are occasions when staff are required to prioritise their clinical workload, and these medicines may not be administered at the exact time prescribed, while acknowledging the impact of anxiety on the consumer. While I have accepted the response form the service, I consider that this is an area of improvement, to ensure that the service has adequate staffing to enable consumer needs and preferences to be met with timely administration of medicines.

In relation to behaviour management for Consumer B, I consider the service did not demonstrate effective management of the consumer’s behavioural responses. In coming to my finding, I have considered the information and evidence provided by the service, and the evidence provided in the Assessment Team report. I have considered that the service appropriately referred Consumer B to Dementia Support Australia (DSA) and the Residential Outreach Team in March 2021. Further, I have accepted the service’s explanation regarding Consumer B’s current companionship with another consumer, and subsequently, accept that staff did not report these occurrences, or attempt to intervene. However, I have considered that at the time of the Assessment Contact, the service did not demonstrate effective management of Consumer B’s responsive behaviours by implementing and trialling the recommendations made by DSA and the Outreach Team to reduce the behavioural responses, and the impact of distress and risk to other consumers and support the needs of Consumer B. Specifically, the service was unable to demonstrate effective implementation of meaningful activities and engagement, recommended by DSA and the Residential Outreach Team. The service provided both reports in their response, which recommended strategies, including (but not limited to):

* Engagement in activities the consumer enjoys when staff presence is reduced.
* Provide meaningful activities and engagement. Without opportunities for meaningful engagement, the likelihood of becoming restless and bored, and seeking out opportunities for affection and connection with other consumers increases.
* Incorporate activities throughout the day which reflect the consumers past hobbies and interests, rather than relying on lifestyle staff to initiate activities, as this is a basic component of consumer centred care.
* Therapeutic touch.

In coming to my finding, I have relied on the Assessment Team’s observations, and staff interviews which indicated that there are no planned activities or stimulation (meaningful engagement) for Consumer B and the service relies on lifestyle staff and the programs available in an adjoining unit. As such, I consider that the service has not effectively managed the risks associated with Consumer B’s responsive behaviours and the impact of distress and risk to other consumers and support the needs of Consumer B.

In relation to the diabetes management of two consumers, I have accepted the service response and explanation. In coming to my finding, I have considered the delay in finalising a diabetes management plan for Consumer C reasonable in order to optimise the management plan and mitigate the risk for and support the consumers independence and autonomy with managing their own diabetes. Further, I consider that there was no impact to Consumer D in relation to the miss-filing of their current diabetes management plan. However, I consider this is an area of improvement for the service, to ensure all consumers with diabetes have a current management plan that is in accordance with their needs. I acknowledge that following the Assessment Contact, the service took action and reviewed the diabetes management plans of all consumers diagnosed with diabetes.

Based on the reasons detailed above, I find the provider, in relation to Eldercare Allambi, to be Non-compliant with Standard 3 Requirement (3)(b).

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The Assessment Team found that the service demonstrated that when there is a deterioration or change in a consumer’s health or functional capacity, the condition is recognised and responded to in a timely manner, in relation to two consumers. The Assessment Team provided the following information and evidence in relation to their recommendation of met in this Requirement:

* The Assessment Team reviewed the files of one consumer who experienced an acute incident following lunch that required first aid action due to low saturation levels. The Assessment Team found that the service took appropriate immediate action, including suctioning, vital observations, application of oxygen and saturation monitoring. In addition, the service appropriately contacted the medical officer and the consumer was reviewed and transferred to hospital in a timely manner. Following the incident, the service reviewed the consumer’s dietary requirements, was reviewed by a speech pathologist and care plan updated following recommendations.
* The Assessment Team reviewed the files of one consumer who experienced clinical deterioration (increase in symptoms) related to terminal cancer. The Assessment Team found the service undertook the appropriate assessments, interventions and monitoring to manage the symptoms. Further the service recognised when the consumer entered the terminal phase of life and provided palliative and end of life care for the consumer.
* The Assessment Team interviewed consumers who indicated that they were satisfied that when they are unwell, staff responded and escalated to their GP if required.
* The Assessment Team interviewed clinical staff who demonstrated knowledge of the service’s governance processes to identify and manage consumers when their condition changes. Further, the Assessment Team observed that the service has policies and procedures relating to recognising and responding to clinical deterioration to support staff practice.

The provider did not submit a response to the Assessment Team’s report in relation to this Requirement.

In coming to my finding, I have considered the evidence documented in the Assessment Team’s report. Based on the information provided to the Assessment Team through staff interviews, observations and documentation sampled, I consider that the service has demonstrated that when there is a deterioration or change in a consumer’s health or functional capacity, the condition is recognised and responded to in a timely manner and the service has appropriate systems and processes in place to support staff.

For the reasons detailed above, I find the provider, in relation to Eldercare Allambi, to be Compliant with Standard 3 Requirement (3)(d).

### Requirement 3(3)(g) Compliant

*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.*

The service was found Non-compliant with Requirement (3)(g) following an Assessment Contact conducted on 11 February 2021. Specifically, the service was unable to demonstrate minimisation of infection related risks through standard and transmission based precautions as use and storage of PPE (personal protective equipment) was not appropriate, and the service did not manage consumers with respiratory infections effectively to reduce the risk of transmission. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Reviewed and revised precautions procedures in relation to isolation of infectious consumers, use and storage of PPE and included communication to staff regarding the procedural changes.
* Undertook an audit of staff competency between May and June 2021 related to infection control, including, but not limited to, donning and doffing of PPE, social distancing and mask wearing.
* Undertook an audit of staff access to relevant infection control policies, procedures and protocols to ensure staff compliance. As a result of the audit, the service developed an action plan to address deficiencies identified.

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

* The Assessment Team viewed the updated infection control and precaution procedures, and information that staff had received training in relation to infection control and minimisation of infection related risks.
* The Assessment Team interviewed staff who demonstrated knowledge of the updated procedures and processes to minimise infection related risks. Further, staff demonstrated knowledge of consumers who had current precautions in place, including the appropriate PPE and interventions to prevent and control infection.
* The Assessment Team observed staff utilising appropriate PPE, practicing hand hygiene and correct donning and doffing procedures.

The provider did not submit a response to the Assessment Team’s report in relation to this Requirement.

In coming to my finding, I have considered the evidence documented in the Assessment Team’s report. Based on the information provided to the Assessment Team through staff interviews, observations and documentation sampled, I consider that the service has demonstrated effective minimisation of infection related risks through standard and transmission based precautions.

For the reasons detailed above, I find the provider, in relation to Eldercare Allambi, to be Compliant with Standard 3 Requirement (3)(g).

# STANDARD 4 Services and support for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team assessed Requirement (3)(g) in this Standard at this Assessment Contact. All other Requirements in this Standard were not assessed. Therefore, an overall assessment of this Standard has not been completed.

The Assessment Team have recommended Requirement (3)(g) in this Standard as met. The Approved Provider did not submit a response to the Assessment Team’s report in relation to the Requirement. The Assessment Team found the service was able to demonstrate that when equipment is provided, it is safe, suitable, clean and well maintained.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 4 Requirement (3)(g) and find the service Compliant with Requirement (3)(g). The reasons for my finding are detailed in the specific Requirement below.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

The Assessment Team found the service demonstrated that when equipment is provided, it is safe, suitable, clean and well maintained. The Assessment Team provided the following information and evidence in relation to their recommendation of met in this Requirement:

* The Assessment Team observed equipment used by lifestyle staff, inside and outside, that was clean and well maintained including observing that alcohol wipes were located in the vicinity of the equipment with signage relating to infection control requirements.
* The Assessment Team interviewed consumers who confirmed that they feel safe when using equipment, and staff provide support for the safe use of the equipment.
* The Assessment Team interviewed three consumers who utilise electric wheelchairs. While the Assessment Team observed one chair to be dusty, two of the consumers stated that staff clean their chairs, however one consumer stated they were required to prompt staff to clean their chair.
* The Assessment Team viewed maintenance records and registers which demonstrated the service has systems in place for preventative and reactive maintenance.

The provider did not submit a response to the Assessment Team’s report in relation to this Requirement.

In coming to my finding, I have considered the evidence documented in the Assessment Team’s report. Based on the information provided to the Assessment Team through staff and consumer interviews, observations and documentation sampled, I consider that the service has demonstrated that where equipment is provided, it is safe, suitable, clean and well maintained.

For the reasons detailed above, I find the provider, in relation to Eldercare Allambi, to be Compliant with Standard 4 Requirement (3)(g).

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) in this Standard at this Assessment Contact. All other Requirements in this Standard were not assessed. The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team assessed Requirement (3)(a) in this Standard at the Assessment Contact and recommended Requirement (3)(a) as not met as the service was unable to demonstrate that the workforce is planned to enable, and the number and mix of the workforce enables the delivery of safe quality care and services. Consumers, staff and representatives reported there was insufficient staff which impacted consumer care. I have also considered evidence presented in Standard 3 Requirement (3)(b) in the Assessment Team’s report in coming to my finding in relation to Standard 7 Requirement (3)(a). The Approved Provider submitted a response and disagreed with the Assessment Team’s report and provided further information to support their response.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the Provider’s response to come to a view of compliance and find the service Non-compliant with Standard 7 Requirement (3)(a). The reasons for the findings are detailed in the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team found the service was unable to demonstrate that the workforce has sufficient numbers and skill mix of staff to provide safe and quality care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* The Assessment Team interviewed five consumers and one representative who stated:
* One consumer (Consumer E) stated staff are the worst between 3:00 – 11:00pm.
* One consumer (Consumer F) stated that staff take a long time to get to them as they are very busy.
* One representative stated weekends are the worst as there is one RN looking after the area where their family member resides. The representative stated that they observe consumers not being attended to in a timely manner, and they call for assistance on behalf of other consumers.
* One consumer (Consumer G) stated they receive assistance with showering every day, however staff are very rushed.
* One consumer (Consumer H) stated the consumer opposite them (Consumer I) calls out frequently, and they attend to the consumer to ask what they need. Further, Consumer H stated that they do not always receive a shower and this happens often and they do not receive pain medication on time, and it can be up to 90 minutes late.
* Consumer I stated that the only way they can get staff attention is to call out, however that does not work either. The consumer calls for assistance to toilet or when their continence aid is soaking wet.
* Care staff interviewed stated that there is insufficient staff which results in consumers not being attended to with their continence care and showers, and as such consumers have soaking wet continence aids, and this happens often.
* The Assessment Team provided evidence in Standard 3 Requirement (3)(b) where the Assessment Team interviewed care and clinical staff who stated they are not always available to supervise Consumer A as they are busy attending to other consumers, and this results in falls. The representative for Consumer A also stated they considered there was insufficient staff in the memory support unit resulting in falls for their family member. Further, staff stated they do not have time to provide meaningful activities to consumers in memory support areas.
* The Assessment team reviewed call bell data reports for three months which indicated 96.5% of call were answered in under 10 minutes, and the average response time 2 minutes and 50 seconds.
* The Assessment Team interviewed management and staff who provided contextual information related to the consumers who expressed there was insufficient staffing resulting in delayed assistance and missed care. Specifically:
* Care staff stated one of the consumers has specific preference regarding which staff members assist with hygiene and will refuse showering if those staff members are not rostered that day.
* Management stated that the consumer who calls for assistance uses their call bell continuously and has a history of cerebral atrophy, poor bladder control, and requests continence aid changed every two hourly, and when checked by staff, the aids are partially dry. Management stated staff attend in a reasonable time frame when the consumer requests assistance.

The Assessment Team interviewed management regarding systems and processes for planning the number and mix of workforce required.

* As occupancy rates increase or decrease, so does the number of care hours provided each day.
* The service is above industry average for care hours provided per consumer.
* Consumer acuity and care needs determines shift allocation.
* Staff feedback, incidents and call bell data informs management regarding number and mix of staffing. Calls unanswered for more than 15 minutes were investigated.

The provider submitted a response to the Assessment Team’s report which addressed the Assessment Team’s findings in relation to Standard 7 Requirement 3(a), stating that the Assessment Team’s report does not provide sufficient evidence that the Requirement is not-met and the service has sufficient numbers and hours to deliver safe and quality care to consumers. The provider’s response included (but was not limited to):

* The three month call bell data presented in the Assessment Team report indicates that average call response times are between 2 minutes 50 seconds and 2 minutes 58 seconds, have been consistent over the three months, and this provides evidence that there is a sufficient number of staffing at the service to provide safe and quality care.
* In relation to the feedback provided by the representative for Consumer A referenced in Standard 3 Requirement (3)(b), the service stated that this memory support unit has the highest number of staff at Allambi, and a model of care that includes additional hours to ensure full time supervision in communal areas.
* In relation to the feedback provided by Consumers:
* Consumer E is approaching end of life, and the consumer has developed close relationships with staff who work morning shifts.
* In relation to consumer F, the service provided call bell data that indicated over a two month period, the average response time of 112 call bell activations was 1 minute 55 seconds, with 106 responses less than six minutes.
* The service stated that on following up with the representative interviewed, the representative stated that the information in the Assessment Team report is not reflective of the interview, including that comments about lack of staffing was incorrect.
* In relation to Consumer H, the service stated that they have a diagnosis of a personality disorder, which includes dramatic and overly emotional thinking, unpredictable behaviour and the need for validation for others. Further, they have a narcotic addition and will regularly request additional pain medicine, and is monitored by a pain clinic.
* In relation to Consumer I, provided two months of call bell data which indicated that the average response time was 3 minutes and 10 seconds, indicating timely responses by staff.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the evidence provided by the service in response to the Assessment Team’s report. I acknowledge the findings of the Assessment Team regarding call bell response times and the additional information provided by the service that demonstrated timely average response times in relation to Consumer F and Consumer I. However, in coming to my finding I have placed weight upon the Assessment Team’s staff interviews in relation to missed care, consumer’s needs not being met in a timely manner and inability to provide activities to consumers in memory support unit. Further, I considered that the service has not demonstrated effective consideration of consumer acuity in determining workforce requirements, or how the service effectively utilises staff feedback to understand impact in relation to staffing numbers.

For the reasons detailed above, I find the provider, in relation to Eldercare Allambi, to be Non-compliant with Standard 7 Requirement (3)(a).

# 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 consumers with responsive behaviours have a behavioural support (management) care plan that addresses the triggers and promotes consumer wellbeing and reduction of responsive behaviours, including consideration, implementation and evaluation of recommendations made by external advisory services.
* Ensure consumers who experience swallowing deficits are referred to speech pathologists appropriately to ensure assessment and recommendations to reduce the risks due to swallowing deficits.
* When consumers experience a change in condition resulting in changed care, ongoing monitoring occurs and is documented to enable sufficient evaluation of the consumers care needs and care provided.

**Standard 7 Requirement (3)(a)**

* Appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in alignment with consumers care needs and acuity.