Hawdon House

Performance Report

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**Commission ID:** 6005

**Provider name:** Riverland Mallee Coorong Local Health Network Incorporated

**Assessment Contact - Site date:** 14 September 2021 to 16 September 2021

**Date of Performance Report:** 29 October 2021

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# 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

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** |  |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(d) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(a) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(c) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 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 consumers, representatives, staff and others;
* the provider’s response to the Assessment Contact - Site report received 12 October 2021; and
* the Performance Report dated 1 February 2021 for the Site Audit conducted 21 September 2020 to 25 September 2020.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Assessment Team assessed Requirements (3)(d) and (3)(f) in Standard 1 Consumer dignity and choice as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(d) and (3)(f) in Standard 1. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* the service had not supported one consumer to take risks associated with an activity of preference to support them to live the best life they can; and
* the service had not ensured each consumer’s privacy was respected.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(d) and (3)(f) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirements (3)(d) and (3)(f) in Standard 1 Consumer Dignity and choice. I have provided reasons for my finding in the specific Requirements below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service had not supported one consumer to take risks associated with an activity of preference to support them to live the best life they can. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed all consumers’ care plans to include goals, preferences and, where required, choices related to taking risks.
* Surveyed consumers to ascertain if they are partaking in their preferred activities, including being supported to take risks.
* Held conversations with the consumer highlighted in the Site Audit report relating to their chosen activity. Risks were discussed and a support plan developed.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers confirmed they are supported to make their own choices and are not prevented from doing things that are important to them.
* Risk assessments are completed on entry, including for consumers who wish to take risks. Risks are documented on Dignity of Choice/Risk or Restraint forms and a Risk activity register is maintained to monitor consumers supported to take risks.
* Care files demonstrated activities consumers choose to undertake which include an element of risk have been identified, associated risks documented and discussed in consultation with the consumer and or representative and strategies to minimise or mitigate risks implemented. Involvement of allied health specialists was noted, where required.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

The service was found Non-compliant with Requirement (3)(f) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service had not ensured each consumer’s privacy was respected. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented behaviour reviews, monitoring and management strategies for consumers with wandering and intrusive behaviours to ensure other consumers are not impacted by their behaviour.
* Held conversations, and sent electronic messages to staff reminding them the service is the consumers’ home and advising staff to respect their privacy.
* Management is monitoring consumers’ privacy through observations of staff practice, consumers’ behaviours and Consumer experience surveys.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers confirmed staff and other consumers respect their privacy and advised staff knock on their door before entering their room.
* Staff confirmed they ensure consumers’ privacy is respected and confidential information is secure, and described practices to support consumer privacy and confidentiality.
* Consumer information was observed to be securely stored, and consumers’ privacy respected during provision of care and services.
* Consumer experience surveys conducted in November 2020 and March 2021 demonstrated most consumers were satisfied staff treat them with respect.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(f) in Standard 1 Consumer dignity and choice.

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is Non-compliant as the one Requirement assessed has been found Non-compliant. The Assessment Team assessed Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(e) in Standard 2. This Requirement was found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not effectively review three consumers’ care and strategies following several incidents of either behaviours or falls which were either impacting other consumers or resulting in injury for the consumer who has had several falls. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit. However, at the Assessment Contact, the Assessment Team found care and services had not been consistently reviewed or documentation updated following changes in circumstances or condition, particularly in relation to wounds or that review processes included a review of actual care plans. The Assessment Team have recommended Requirement (3)(e) not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(e) Non-compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team were not satisfied care and services had been consistently reviewed or documentation updated following changes in circumstances or condition, particularly in relation to wounds or that review processes included a review of actual care plans. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* The consumer entered the service in April 2021 for two weeks respite and developed a stage II pressure injury. The consumer’s condition deteriorated following a hospital admission in May 2021, including skin integrity, mobility and swallowing abilities. Consumer A returned to the service 10 days after the hospital admission, however:
* The skin assessment and care plan were not reviewed and updated to reflect current skin condition or new management strategies following identification of pressure injuries in April 2021.
* While there was evidence of more than one pressure injury, only one wound management plan was in use and did not provide a clear description of the wound(s) or enable effective understanding of healing status.
* No assessments were completed despite a change in condition, including deterioration in pressure injuries.
* Eight days post entry, Consumer A was assessed by a Physiotherapist as staff were struggling with mobility and transfers. No new strategies were implemented; however, staff were provided verbal guidance.
* Following return from hospital, progress notes indicate staff had been struggling to transfer the consumer with a lifter and were nursing the consumer in bed. Consumer A was seen by a private Physiotherapist, however, care and services were not reviewed by the service.
* Following return from hospital, staff documented Consumer A had been reviewed by a Speech pathologist whilst in hospital due to coughing while eating and documented ‘please refer to notes.’
* Speech pathologist notes were not available on the electronic system and no assessments, including a nutrition and hydration assessment, were completed during the entirety of Consumer A’s respite stay.
* Two clinical staff and clinical management acknowledged Consumer A should have been re-assessed following identification of new pressure injuries and on return from hospital.

Wound care

* In relation to Consumer B, following identification of a pressure injury, care and services were not reviewed, investigation into cause not undertaken and trial of new pressure relieving strategies were not initiated. Other than changes to dressing products, staff could not describe how care had changed as a result.
* In relation to Consumer C, following identification of a wound in August 2021 and a multi-resistant infection in September 2021, a skin assessment was not completed, with the last assessment dated June 2021. Additionally, care and services were not reviewed or new management strategies or infection control processes identified.
* Two clinical staff were unaware of the recent multi resistant infection result and could not describe preventative or management strategies relating to the wound.

Care plan review process

* There were no documented falls prevention strategies in the mobility or dexterity subsection of the care plan for Consumer D. Management identified interventions were listed in the free-text box of the falls risk assessment tool, however, this did not translate into the care plan.
* Management acknowledged the full care plan had not been reviewed, rather, the assessment had been reviewed and, therefore, the issue not identified.
* A care plan still identified Consumer E as having a stage III pressure injury, despite quality indicator reports documenting the injury as a stage IV injury between October and December 2020 and unstageable since January 2021. Management acknowledged this had not been identified.
* Clinical management confirmed review processes involved reviewing and updating individual assessments, rather than a review of the actual care plan.
* Management advised they believe assessments would feed into the care plan, however, acknowledged this has not been the case.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Four monthly care plan reviews to consistently include a full review of the entire care plan.
* Over 50% of care plan reviews to be examined over the next three months.
* Ensure preventative measures to maintain skin integrity are clearly documented in care plans.
* Review the admission checklist to re-prioritise assessments.

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not effectively review three consumers’ care and strategies following several incidents of either behaviours or falls which were either impacting other consumers or resulting in injury for the consumer who has had several falls. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Undertaking regular meetings with consumers to identify changes to preferences, needs and goals at four monthly care plan reviews and monthly meeting forums.
* Implemented an Associate nurse unit manager duty statement to assist and ensure prompt and timely response to identified changes in the provision of consumer care, needs and preferences.
* A Gantt chart has been developed detailing daily tasks and responsibilities of Associate nurse unit managers.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits 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, care and services were not regularly reviewed for effectiveness or in response to changes in consumers’ circumstance or incidents which impacted the goals, needs and preferences of consumers.

I have considered for Consumer A, assessment and review processes were not initiated to identify the consumer’s required care and service needs despite notable changes in the consumer’s condition following return from hospital. Additionally, while assessments by allied health professionals occurred in relation to mobility and safe swallowing requirements, information and/or management strategies were not initiated, available or reviewed to assist staff to provide safe and effective care and services.

In relation Consumers B and C, I have considered that appropriate assessment, monitoring and review of care needs and management strategies, specifically skin care, were not initiated to minimise further impact on consumers’ health and well-being. Staff could not describe any changes to either Consumer A or Consumer B’s care in response to identification of wounds and/or infections and two clinical staff were unaware of Consumer C’s newly diagnosed infection.

I have also considered that while care plan reviews were noted to have occurred at regular intervals, review processes have not been effective. Review processes do not include review of the care plan document, with only individual assessments being reviewed and updated. As such, care plans sampled were not reflective of consumers’ current care and service needs nor did they provide sufficient, accurate information to guide staff when delivering care and services to consumers.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and monitoring with consumers.

# 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 Non-compliant as two of the three Requirements assessed have been found Non-compliant. The Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(d) in Standard 3 Personal care and clinical care as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b) and (3)(d) in Standard 3. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* staff’s ongoing use of as required pain medication for one consumer without effective evaluation had not supported the consumer to receive effective clinical care;
* two consumers’ ongoing wandering and intrusive behaviours were known to staff but had not been effectively managed and had been impacting on the lives of other consumers; and
* staff had not effectively responded to changes in consumers’ health or actioned changes following incidents

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(d) met. However, the Assessment Team were not satisfied the service demonstrated:

* each consumer received safe and effective care in relation to chemical and mechanical restraint and wound care; and
* effective management of high impact or high prevalence risks, specifically in relation to pressure injuries, for each consumer.

The Assessment Team have recommended Requirements (3)(a) and (3)(b) not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirements (3)(a) and (3)(b) and Compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care. I have provided reasons for my findings in the specific Requirements below.

### Assessment of Standard 3 Requirements

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

*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.*

The Assessment Team were not satisfied each consumer received safe and effective care in relation to chemical and mechanical restraint and wound care. The Assessment Team’s report provided the following evidence relevant to my finding:

Wound care

* For four consumers sampled:
* wound charting had not been used in line with the organisation’s wound care processes. Staff had on some occasions documented wound progress in a ‘free text’ box in the wound management plan or updated the plan to reflect a change in dressing status.
* A full assessment and update on the wound was not consistently documented, including the dimension, staging, description and consistent angle of photographs.
* Staff confirmed they do not routinely document the size and stage of wounds, however, acknowledged this should be done.
* Staff advised they document changes to, or deterioration of, the wound in the free text box of the management plan and will amend the management plan as needed, thereby overriding previous comments. They do not use wound charting.

Restrictive practices

* Of the two occasions Consumer A was administered as required psychotropic medication, the medication was not administered as a last resort following non-pharmacological strategies on one occasion.
* Consumer B mobilises independently using an electric wheelchair. Management advised they consider the seat belt in the electric wheelchair a mechanical restraint.
* A dignity of choice/risk or restraint form, completed in November 2020, does not identify risks of using a seat belt or include information pertaining to management of associated risk.
* Two care and clinical staff and clinical management were unable to describe risks of using the seat belt, monitoring requirements or management strategies for minimising harm.
* For three consumers subject to chemical and mechanical restraint, Residents Activity at Risk/Restraint Use Assessment forms did not include:
* Details of how the restrictive practice is to be used, including duration and frequency.
* Alternative strategies for addressing behaviour of concern. The form documented ‘refer to behaviour management plan for non-pharmacological strategies.’
* How the restrictive practice is to be monitored and reviewed.
* Behaviour management support plans for two consumers did not include any information pertaining to use of restrictive practices as required by the amendments to Quality of Care Principles 2014.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Update Behaviour support plans to reflect new legislation related to restrictive practices.
* Implement a restrictive practice register that supports compliance with legislation.
* Education to be provided to all staff relating to administration of as required medication as a last resort and documenting non-pharmalogical strategies.
* Site Wound care lead established and three Wound care champions to be assigned.
* Commence monthly pressure injury and chronic wound audits for a six month period.
* Ensure all wound assessments and management templates are consistently utilised and completed.

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found staff’s ongoing use of as required pain medication for one consumer without effective evaluation had not supported the consumer to receive effective clinical care. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented a performance monitoring framework incorporating a number of clinical topics, including pain.
* Developed a daily huddle schedule. Huddles are used to provide information to staff on best practice clinical care in alignment with current policies and procedures.
* Education provided to staff relating to high-risk areas, such as elder abuse, clinical deterioration, pain management and behaviour management.
* Quality review schedule audit reports are conducted and disseminated to staff monthly, including use of short observational frameworks for inspection (SOFIs).
* SOFIs for falls and medication management were conducted in August 2021 with 100% compliance achieved.
* Implemented a weekly operational report with all identified risk transferred to the High-Risk Resident meetings for weekly discussion and action.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits 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, each consumer was not receiving safe and effective clinical care that was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to behaviour management and restrictive practices.

Evidence documented in the Assessment Team’s report demonstrates wound management plans for four consumers were not consistently completed, including a full assessment and update on the wound. Additionally, while staff confirmed they do not routinely document size and stage of wounds, staff acknowledged this should be done. I find it is reasonable for consumers to expect wounds to be monitored at each treatment, including staging and measurements of the wound undertaken in line with best practice care. Such practices would ensure wound progression is monitored and wound deterioration is identified in a timely manner. I have also considered that the service’s wound care/management documentation processes are not effective with staff indicating previous commentary relating to management and/or progress of the wounds being overridden by new comments when entered into the system. I find this process does not enable effective wound monitoring to occur or for changes in wound appearance to be effectively identified.

I have considered that while use of a restrictive device for Consumer B is considered a mechanical restraint by management, there is no evidence to demonstrate risks relating to use of the device have been identified. Additionally, care and clinical staff were not familiar with the risks associated with the use of the device, monitoring requirements or strategies to minimise harm while the device is in use. I have also considered that documentation relating to use of chemical restraint for three consumers did not include key information to guide use of restrictive practices in line with best practice care and to ensure use of restraint was minimised. Additionally, I find the service has not complied with legislative requirements relating to restrictive practices with all required information not being included in behaviour support plans sampled.

In relation to Consumer A, I have considered that while as required psychotropic medication was not administered as a last resort on one of two occasions, there is no indication that this practice is a systemic issue. I would encourage the service to continue to ensure staff are aware of their responsibilities to implement non-pharmalogical interventions prior to administering as required psychotropic medications to manage consumer behaviours.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### 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 were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically in relation to pressure injuries. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* Consumer A developed a stage II pressure injury during a two week respite stay in April 2021. The representative expressed concern the consumer had not received adequate pressure area care which resulted in the development and deterioration of pressure injuries.
* A skin assessment completed on entry identified the consumer as at risk of pressure injuries. A stage II pressure injury was identified seven days post entry. Management acknowledged staff may have missed the pressure injury at stage I during the initial skin assessment on entry and personal care.
* On return from a hospital admission in May 2021, progress notes indicate the pressure injury had worsened, however, a new skin assessment was not completed.
* Progress notes and a photograph in May 2021 show an entirely different wound, indicative of necrotic tissue. A new management plan or assessment was not completed, or stage, size or description noted.
* Repositioning charts for a five day period in May 2021 indicate pressure area care was not consistently attended four hourly in line with the skin assessment strategies.

Consumer B

* Consumer B entered the service in June 2020 with chronic pressure injuries. A skin assessment was not completed until 37 days post entry.
* The skin assessment identified Consumer B as being at high risk of a pressure injury and did not indicate pressure injuries had been identified.
* The wound management plan requested daily dressing changes, however, documentation does not provide evidence of review on multiple days, including eight of 15 days in September 2021.
* Over the course of 13 months, one pressure injury deteriorated from a stage I to unstageable and has remained unstageable since August 2021.

Consumer C

* A skin assessment dated June 2021 identified Consumer C as at high risk of pressure injuries.
* A wound on a big toe was first documented in August 2021 and identified as infected in September 2021. A wound swab returned a positive result for a multi resistant organism. This was not reflected in care documentation.
* A photograph of the wound demonstrates a small wound was evident on the left second toe; this was not commented upon in documentation.
* Photographs seven days later suggest the wound remained infected. No further strategies were documented.
* The wound management plan requested daily dressing changes, however, documentation indicates at least three days were missed.
* The service did not demonstrate new strategies have been considered or implemented to prevent further or recurrent skin breakdown. Clinical staff and management could not detail strategies for minimising and preventing skin breakdown to his feet.
* The representative indicated while the consumer is reviewed frequently by the Medical officer, they were concerned infections are recurring.

Consumer D

* The care plan indicates Consumer D as being at risk of skin breakdown.
* Documentation in August 2021 indicates an area, which had previously been treated for a stage I pressure injury was increasingly sore and painful. Following a Medical officer review, the consumer was commenced on antibiotics the following day due to evidence of infection
* The wound management plan requested daily dressing changes, however, documentation indicates at least three days were missed over a two-week period.
* The skin assessment was reviewed, however, no new strategies were implemented.
* Other than using a cradle at the foot of the bed, clinical staff and management could not detail further strategies for managing the wound.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Staff trained to accurately assess and identify risks of skin breakdown with adequate preventative strategies documented.
* Use of Wound specialists for consultation, review and expertise.
* Training on documenting wound management in the electronic system.

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found two consumers’ ongoing wandering and intrusive behaviours were known to staff but had not been effectively managed and had been impacting on the lives of other consumers living at the service. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Developed a falls checklist which includes neurological observations, open disclosure, completing pain assessments and reviewing and updating falls risk assessments.
* A daily form is distributed to staff each shift and clinical management check to ensure tasks, such as neurological observations, are completed.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits 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, wound documentation and pressure injury management and/or strategies were not being effectively managed or undertaken.

In relation to Consumer A, while the consumer was assessed as at risk of pressure injuries, management strategies implemented were not effective in minimising the consumer’s risk with a stage II pressure injury being identified seven days post entry. Additionally, despite a marked deterioration in the pressure injury following return from hospital, a new skin assessment, management plan or a detailed description of the wound were not completed to minimise further deterioration or new pressure injury development.

For Consumer B, a skin assessment was not completed until approximately five weeks post entry despite the consumer having chronic pressure injuries on admission. Additionally, wound treatments were not conducted in line with the wound management plan. One pressure injury is noted as deteriorating to an unstageable wound in a period of 13 months.

In relation to Consumer C, wound treatments have not been conducted in line with the management plan and new management strategies have not been initiated in response to an ongoing infection and recurrent skin breakdown.

For Consumer D, wound treatments have not occurred in line with the wound management plan. I have also considered that while the skin assessment was completed on identification of a skin integrity issue, further management strategies had not been implemented and staff could not detail further skin management strategies other than use of a bed cradle.

I have considered that for the consumers highlighted in the Assessment Team’s report, risks relating to skin breakdown were noted as at risk or high risk. I find it is reasonable, considering the identified risks to the consumers and the nature of the wounds described, for consumers to expect treatments are undertaken in line with wound management plans, skin assessments are completed in response to changes in skin integrity and management strategies are reviewed and/or new strategies implemented to minimise further impacts on consumers’ health and well-being and to ensure comfort is maintained.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### 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 service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found staff had not effectively responded to changes in consumers’ health or actioned changes following incidents. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Education provided to staff relating to clinical deterioration, falls and post fall management.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* A range of monitoring tools and assessments are completed on entry and on an ongoing basis and are used to identify and evaluate changes to consumers’ health, condition and abilities.
* Where changes to consumers’ health were identified, documentation demonstrated further charting and monitoring processes had been implemented and referrals to Medical officers and/or allied health specialists initiated.
* Representatives and consumers confirmed appropriate and prompt action is taken in response to deterioration in consumers’ health and recalled assessments, observations and medical reviews occurring.
* Representatives confirmed they had been informed of deterioration and changes in consumers’ health and were satisfied their relatives were looked after.
* Clinical and care staff were familiar with sampled consumers’ care needs and described actions they had taken in response to changes in consumers’ health and well-being.
* Care staff indicated where changes to consumers’ health were identified, clinical staff always acted on their concerns and escalate care accordingly.
* Monitoring processes, including 24-hour progress note reviews alert clinical management of deterioration and changes in consumers’ condition and status. There are after hours on-call processes to guide and support clinical decision making.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

# STANDARD 4 Services and supports 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)(a) in Standard 4 Services and supports for daily living as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in Standard 4. This Requirement was found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not support two consumers to engage in activities to optimise their well-being and quality of life. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(a) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(a) in Standard 4 Services and supports for daily living. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not support two consumers to engage in activities to optimise their well-being and quality of life. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed all consumers’ care plans to include goals and preferred activities.
* Implemented a spreadsheet to ensure care and service review dates are monitored.
* Consumers and/or representatives are involved in the care plan review to ensure activities of daily living documented and provided reflect consumers’ needs, goals and preferences.
* Consumers are regularly surveyed about one-on-one and group activities which informs the activity calendar.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers described in various ways how staff support them in their daily living, including attending activities of interest to them.
* Consumers’ care documentation demonstrated assessment and consultation processes assist to identify each consumer’s needs, goals and preferences for care and services.
* Assessments assist to identify consumer preferences for life history, activities of daily living, including nutrition and hydration; emotional and spiritual; and leisure and lifestyle.
* Staff demonstrated an understanding of what was important for consumers sampled.
* Activities scheduled on the activity calendar were reflective of sampled consumers’ preferences.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(a) in Standard 4 Services and supports for daily living.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Assessment Team assessed Requirement (3)(c) in Standard 6 Feedback and complaints as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in Standard 6. This Requirement was found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service was not using best practice complaints processes to support effective resolution of complaints or open disclosure processes. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(c) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service was not using best practice complaints processes to support effective resolution of complaints or open disclosure processes. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented evaluation of complaints.
* Introduced feedback processes to aged care consumers.
* Open Disclosure training added to the mandatory training schedule.
* Developed prompts to the service’s computer desktop screens to remind staff regarding the open disclosure process.
* Weekly education sessions have included information regarding open disclosure and the importance of an expression of regret.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Overall, consumers considered they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken in response.
* Consumers and representatives confirmed an open disclosure process is used when things had gone wrong, staff had been open about any mistakes and an apology provided.
* Management provided examples of where open disclosure principles had been used, including in relation to medication incidents and not informing a representative of a consumer’s fall in a timely manner.
* Staff described open disclosure processes and gave examples of how it had been applied.
* Training documentation and attendance sheets sampled confirmed staff participation in High risk training where open disclosure content was reinforced.
* A complaints log is maintained and demonstrated complaints are followed through to completion, including action taken, consumer feedback, outcome and a description of when apologies were made to consumers.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

# 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 Quality Standard is Non-compliant as one of the three Requirements assessed has been found Non-compliant. The Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(c) in Standard 7 Human resources as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b) and (3)(c) in Standard 7. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* feedback from consumers, representatives and staff indicated staff were not always available to supervise and assist consumers in a timely manner, including responding to call bells or assisting consumers to engage in activities of their choice at agreed times;
* feedback from consumers indicated some staff interactions with three consumers had not demonstrated kindness or respect; and
* while staff had been provided extra support and supervision by additional clinical managers, staff had not demonstrated they were able to effectively identify and manage risks associated with consumers’ care, respond appropriately or in a timely manner to changes in consumers’ clinical health status or respond to ongoing behavioural incidents.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(b) met. However, the Assessment Team were not satisfied the service demonstrated the workforce is competent and has the knowledge and skills to effectively perform their roles in relation to wound care and have recommended Requirement (3)(c) not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(c) and Compliant with Requirements (3)(a) and (3)(b) in Standard 7 Human resources. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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 service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found feedback from consumers, representatives and staff indicated staff were not always available to supervise and assist consumers in a timely manner, including responding to call bells or assisting consumers to engage in activities of their choice at agreed times. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Daily call bell audits are being conducted and where responses greater than the key performance indicator, this is addressed in real time with the staff involved.
* Staffing numbers have been increased above the staffing ratio according to consumer requirements.
* Established a casual staffing pool to fill any unplanned leave shifts.
* Conducted a review into the process for identifying consumers’ needs in relation to staff allocation and rostering.
* Reviewed role descriptions and individual staff classifications.
* Purchased new DECT phones which are integrated with the call bell system making it more effective.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service demonstrated processes to ensure 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.
* Roster documentation demonstrated there are processes to manage staffing shortfalls.
* Most consumers and representatives were satisfied with staffing levels and responsiveness of staff.
* Most staff were happy with staff allocations and said they had improved.
* There are processes to monitor staffing, including daily allocation checks and monthly call bell audits.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(a) in Standard 7 Human resources.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found feedback from consumers indicated some staff interactions with three consumers had not demonstrated kindness or respect. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Training provided to staff relating to the organisation’s Code of ethics, the Quality Standards and kindness.
* Commenced Consumer experience surveys to see what is important to consumers.
* Focus groups were undertaken relating to dignity and respect. This meeting is scheduled three times a week and topics discussed have been added to the training calendar.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers and representatives said staff were usually kind and respectful. However, three consumers indicated staff are sometimes rushing or in a hurry.
* Training records demonstrated staff have received training in the organisation’s Code of ethics and the Quality Standards.
* Management said monthly training focusing on the Quality Standards has embedded staff understanding of the person-centred service and how this impacts consumers.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(b) in Standard 7 Human resources.

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

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team were not satisfied the service the workforce is competent and has the knowledge and skills to effectively perform their roles in relation to wound care. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two of four consumers and/or representatives sampled expressed concern regarding wound care.
* Consumer files sampled demonstrated staff did not follow wound care guidelines or instruction documents or demonstrate consistent knowledge in identifying and responding to pressure area care and wounds.
* Wounds were not always identified and assessed in a timely manner and wound dimensions, depth and staging for the four sampled consumers were not consistently recorded, demonstrating staff were not consistently utilising and completing skin assessment and wound management documentation in accordance with best practice.
* Staff sampled indicated:
* they do not routinely document the size and stage of wounds but acknowledged this should be done;
* they document changes to or deterioration of the wound in the management plan but have not considered using a separate wound charting tool;
* wound management has been discussed at staff meeting forums and management have identified wound care training as a need;
* confirmed they need training in identification, staging, documentation and dressing types to be used on different wounds; and
* while they can call on the community nurses for assistance and have utilised their specialised knowledge in wound care, they are waiting for specific training to be conducted to assist them with effective day-to-day management of wounds.
* Training has been organised on three occasions but has been cancelled due to COVID-19 requirements.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Wound training to be provided to all Leads and wound and skin education to be provided to care staff.
* Wound management quizzes to be developed and undertaken.
* Rolling weekly education on wound care to ensure consistent knowledge in identifying and responding to pressure area care and wounds.

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found that while staff had been provided extra support and supervision by additional clinical managers, staff had not demonstrated they were able to effectively identify and manage risks associated with consumers’ care, respond appropriately or in a timely manner to changes in consumers’ clinical health status or respond to ongoing behavioural incidents. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Education provided to staff relating to clinical deterioration which included case studies to inform and stimulate discussion.
* Staff have completed a two-hour training module covering high risk areas, and monthly compulsory training revising all the Quality Standards (one a month) and what they mean to service delivery.
* Implemented High risk resident management meetings.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits 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 workforce was not sufficiently competent or had the knowledge to effectively perform their roles. In coming to my finding, I have considered the outcomes for consumers highlighted in Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b) which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective clinical care, specifically wound management.

In coming to my finding, I have considered evidence which indicates staff have not competently performed their roles in accordance with best practice or the service’s processes, specifically as it relates to skin care and wound management. Skin and wound management documentation for four consumers was not consistently completed or wounds identified and assessed in a timely manner. For one consumer, despite a marked deterioration in an existing pressure injury following return from hospital, further skin assessments, management plans or a detailed description of the wound were not undertaken. Strategies were not implemented to minimise and/or prevent further skin breakdown for two consumers and for another, despite chronic pressure injuries being evident on admission, a skin assessment was not completed until 37 days post entry despite the consumer having chronic pressure injuries on admission. Additionally, while staff confirmed they do not routinely document size and stage of wounds, staff acknowledged this should be done.

I have also considered that the organisation’s systems have not ensured staff practices, skills and knowledge in relation to wound management processes, are monitored and issues relating to the delivery of clinical care identified. Wound care training has been identified as a need and while I acknowledge such training has been impeded by COVID-19 requirements, additional monitoring processes to ensure consumer wounds are managed in line with the service’s processes and best practice have not been implemented to support staff.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(c) in Standard 7 Human resources.

# 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 Quality Standard is Non-compliant as one of the three Requirements assessed has been found Non-compliant. The Assessment Team assessed Requirements (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c), (3)(d) and (3)(e) in Standard 8. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* the organisation’s governance systems were not effective in relation to workforce governance and regulatory compliance;
* the risk management framework had not been effective in identifying ongoing falls and behaviours; and
* the clinical management framework had not been effective in ensuring staff practices were consistent with open disclosure processes and minimising the use of restraint.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(e) met. However, the Assessment Team were not satisfied the service demonstrated:

* effective information management in relation to wound care and regulatory compliance in relation to restrictive practices; and
* effective high impact or high prevalence risks systems and practices in relation to wound management.

The Assessment Team have recommended Requirements (3)(c) and (3)(d) not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(d) and Compliant with Requirements (3)(c) and (3)(e) in Standard 8 Organisational governance. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Compliant

*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.*

The Assessment Team were not satisfied the service demonstrated effective information management in relation to wound care and regulatory compliance in relation to restrictive practices. The Assessment Team’s report provided the following evidence relevant to my finding:

Information management

* Clinical staff reported finding the electronic clinical care system difficult to work with in relation to wound care. During the Assessment Contact, staff were observed being unable to find information, such as wound measurements, reviews and treatment regime.
* Clinical staff reported they document wound information in free text boxes, which erases previous comments. Documentation was noted to be inconsistent in relation to wound size and staging. Staff stated they would benefit from wound management education.
* Wound care documentation demonstrated the of size and stage of the wound was not consistent. These were either not documented, documented under the free text box, or documented under the wound assessment.
  + Photos did not consistently include a ruler to ascertain the size and taken from different angles and distance and wound progress was not systematically documented.
  + Staff did not use wound charts as per the service’s wound care guidelines.
* Management advised the current wound management template in the electronic clinical care system makes effective documentation and monitoring on the progress of wounds challenging.
* Management had recognised staff required further wound care education, including assessments, measurements, documentation and archiving which had been organised, however, was cancelled due to COVID-19 requirements.

Regulatory compliance

* Documentation viewed for one consumer in relation to chemical restraint showed non-pharmacological strategies were listed in the behaviour management plan; however, as required psychotropic medications were not administered as a last resort following non-pharmalogical strategies on one occasion in September 2021.
* For all three consumers sampled subject to chemical and mechanical restraint:
  + Risk assessments did not include details of when the restrictive practice is to be used, alternative strategies for addressing behaviour of concern or how the restrictive practice is to be monitored and reviewed.
  + the behaviour management plan included non-pharmaceutical strategies, however, did not reflect the use of restrictive practices to manage the behaviour of concern.
* A Restraint procedure is currently being reviewed to reflect legislative changes from 1 July 2021, however:
  + The draft procedure did not include legislative requirements to implement Behaviour support plans from 1 September 2021, nor did it guide staff on information to be included in the behaviour support plan in relation to assessment, monitoring, review, evaluation and provision of consent.
* Staff have been provided education and information in relation to behaviour support plan legislative requirements, however, this was not effective as assessments and behaviour management plans were not completed in line with restrictive practices legislative requirements as outlined in the Quality of Care Principles 2014.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Review the Wound management policy to ensure it aligns with best practice and supports the service’s electronic documentation requirements.
* Create a work instruction incorporating a checklist that supports the policy.
* Ensure all wound assessment and management templates are consistently utilised and completed in relation to pressure injuries, wound identification, management and monitoring.

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the organisation’s governance systems were not effective in relation to workforce governance and regulatory compliance. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented a four-monthly consumer personal and clinical care and activities of daily living review process.
* Developed a review schedule, which is allocated to relevant staff, and reports monthly on progress to the Board.
* Training provided to staff relating to high-risk areas, including identification of reportable incidents and timely reporting and Serious Incident Response Scheme legislated requirements.
* Reviewed the staffing roster with the involvement of staff and feedback related to allocation of resources.
* Developed a staffing methodology and implemented a static roster with the option to increase staffing ad hoc as required in line with consumers’ needs.
* Recruitment is ongoing to ensure sufficient staff are available to fill shifts.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. In coming to my finding, I have considered that the evidence presented does not indicate systemic issues with the organisation’s governance systems relating to information management and regulatory compliance.

I acknowledge evidence presented by the Assessment Team demonstrates wound management plans were not consistently completed and wound care documentation is difficult to find on the electronic system. However, I have considered that the evidence presented does not suggest systemic issues relating to the organisation’s overall information management systems. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal and clinical care Requirements (3)(a) and (3)(b) and Standard 8 Organisational governance Requirement (3)(d).

In coming to my finding for this Requirement, specifically information management, I have considered information in the Assessment Team’s report indicating wound care guidelines and processes, and an electronic clinical care system are in place for the management of information pertaining to pressure injuries. The service has a documented Clinical practice guideline on wound care and there are processes to monitor pressure injuries, including through care reviews, weekly high risk meetings, audits, and monthly trending and analysis of clinical incidents. I have also considered that for most of the Standards and Requirements assessed at the Assessment Contact, there are documented policy and procedure documents, consumer files, including care plans and communication processes available to management and staff to guide care and services.

In relation to regulatory compliance, I acknowledge that for three consumers, documentation relating to use of chemical restraint does not include key information to guide use of restrictive practices in line with best practice care and behaviour support plans do not include all information required as legislated. However, I have considered that the evidence presented does not suggest systemic issues relating to the organisation’s overall regulatory compliance systems. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal and clinical care Requirement (3)(a).

In coming to my finding for this Requirement, specifically regulatory compliance, I have considered that based on information in the Assessment Team’s report, there are processes to identify and implement changes in legislation and where changes to legislation have occurred, the organisation has taken measures to ensure staff are made aware of their responsibilities. All staff have received training in relation to the Serious Incident Response Scheme and behaviour management support plan requirements.

I have also considered that the Assessment Team’s report demonstrates the organisation has effective governance systems in relation to continuous improvement, financial governance, workforce governance and feedback and complaints.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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*
4. *managing and preventing incidents, including the use of an incident management system.*

The organisation demonstrated effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system. However, the Assessment Team were not satisfied the service demonstrated effective systems and practices relating to high impact or high prevalence risks systems and practices, specifically wound management. The Assessment Team’s report provided the following evidence relevant to my finding:

* Monitoring processes did not identify staff were not consistently completing wound assessments or documenting wounds, including wound charting, dimensions, description, photographs and staging, in line with best practice or organisational guidelines for four consumers.
* Management had recognised deficiencies in staff understanding and practice in relation to wound care, however, planned wound care training was cancelled.
* Audits completed did not identify deficiencies identified by the Assessment Team or did not inform a review of staff practices, for example:
  + A wound/pressure injury audit conducted in July 2021 for the period May to June 2021 identified some photographs were missing, however, identified assessment and photography was improving and scored 100%.
  + A preventing and managing pressure injuries audit completed in August 2021 scored 100% and showed for the consumers sampled, pressure injury risk assessments had been reviewed, wound care assessments completed, photographs documented, and wounds evaluated.
* Pressure injuries for four consumers sampled were not effectively identified or managed. Care documentation confirmed ineffective assessment and identification of risk and skin breakdown, inconsistent implementation of pressure area care, ineffective management of pressure injuries, and minimal preventative strategies for preventing further deterioration:

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Improve risk management processes for wound management and clinical care in relation to assessment, planning and review.

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the risk management framework had not been effective in identifying ongoing falls and behaviours. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Consumer risks are monitored through weekly High-risk resident management meetings, including review of consumers identified risks and actions taken to prevent and manage risks.
* Monthly audits and monthly reporting to the Board occurs, including in relation to consumer incidents and risks.
* Training provided to staff relating to mandatory reporting requirements and elder abuse.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits 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 did not demonstrate effective risk management systems and practices relating to high impact or high prevalence risks associated with the care of consumers’, specifically management of wounds.

In coming to my finding for this Requirement, I have also considered evidence presented in Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b). I have considered that the evidence presented in these three Requirements, associated with four consumers and several staff practices, indicates systemic issues relating to the organisation’s risk management systems and processes, specifically high impact or high prevalence risks and the management of skin care and wounds.

I consider the service’s monitoring processes, as they relate to high impact or high prevalence risks, were not effective in identifying deficits related to wound management and failures in staff practices. A sample of wound documentation for four consumers included similar inconsistencies relating to lack of documentation of wound dimensions, descriptions, staging and photographs. While an audit process is in place, audits conducted in July 2021 relating to wounds/pressure injuries and August 2021 relating to preventing and managing pressure injuries did not identify any of the deficits highlighted by the Assessment Team. A 100% compliance rating was noted for both audits. As such, actions to reduce and/or mitigate risks are not being effectively identified, assessed or reviewed to improve outcomes for consumers.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### Requirement 8(3)(e) Compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the clinical management framework had not been effective in ensuring staff practices were consistent with open disclosure processes and minimising the use of restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the restraint policy, however, it is yet to be released.
* Implemented a register to record and monitor consumers with restrictive practices in place.
* Training provided to staff relating to restrictive practices and open disclosure.
* The incident management system includes a prompt for staff to document open disclosure.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* In relation to minimising the use of restraint staff have completed restrictive practices education and generally demonstrated understanding of the new restrictive practices legislative requirements. A risky activity register has been implemented which outlines consumers with current restrictive practices in place. Dignity of Choice/Risk or Restraint forms are completed for consumer have restrictive practices applied and generally include risks related to the restrictive practice and consent.
* Policy and procedure documents relating to open disclosure are available to guide staff practice and complaints management processes. Staff and management demonstrated understanding of open disclosure principles and provided examples of application of open disclosure processes following incidents.
* Policy and procedure documents relating to antimicrobial stewardship are available to guide staff practice and understanding. Staff and management demonstrated understanding of antimicrobial stewardship principles and provided examples of application in relation to testing for pathogen and antibiotic use in relation to a wound infection.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Hawdon House, Compliant with Requirement (3)(e) 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.

**Standard 2 Requirement (3)(e)**

* Ensure staff have the skills and knowledge to:
* initiate assessments and develop and/or update care plans, in response to changes in consumers’ health and well-being.
* undertake care plan review process, inclusive of the full care plan, and initiate changes to align with consumers’ current care and service needs.
* Ensure consumer care plans are updated in response to consumers’ changing condition and clinical incidents.
* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* Identify and report changes in consumers’ skin integrity in a timely manner.
* initiate assessments and develop management strategies in response to changes in consumers’ health and well-being, including skin integrity and wounds;
* review and undertake wound treatments in line with management plans, ensuring wound measurements and appearance are routinely documented;
* in consultation with consumers and/or representatives, identify risks related to restrictive devices, develop and implement strategies to mitigate and/or minimise risks and monitor and review strategies for effectiveness; and
* understand legislative requirements in relation to behaviour support plans and develop and implement support plans in line with these requirements.
* Review wound management processes to ensure documentation and review relating to wounds is easily accessible to enable effective monitoring of wound progression.
* Ensure policies, procedures and guidelines in relation to behaviour support plans, restrictive practices and wound management, including assessment, monitoring and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to restrictive practices and wound management, including assessment, monitoring and review.

**Standard 7 Requirement (3)(c)**

* Ensure staff are provided appropriate training to address the deficiencies identified in relating to wound management processes.

**Standard 8 Requirement (3)(d)**

Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers, specifically wound management.