Helping Hand Aged Care - Lealholme Port Pirie

Performance Report

15 Halliday Street
PORT PIRIE SA 5540
Phone number: 08 8633 3233

**Commission ID:** 6173

**Provider name:** Helping Hand Aged Care Inc

**Assessment Contact - Site date:** 25 May 2021 to 26 May 2021

**Date of Performance Report:** 25 August 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 |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(d) | 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 18 June 2021
* the performance assessment report for the Assessment Contact conducted on 17 to 18 February 2021.

# STANDARD 3 NON-COMPLIANTPersonal 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. All other Requirements in this Standard were not assessed at this Assessment Contact.

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirement (3)(b) in this Standard. This Requirement was found to be Non-compliant following an Assessment Contact conducted on 17 to 18 February 2021 where it was found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of one consumer, specifically in relation to clinical risks associated with nutrition and hydration, infection identification and management, wound/pressure injury management and pain management.

The Assessment Team have recommended Requirement (3)(b) in this Standard as not met. The Approved Provider submitted a response to the Assessment Team’s report and have strongly refuted the Assessment Team’s findings and provided further information and evidence to support their assertion that this Requirement should be met.

Based on the Assessment Team’s report and the Approved Provider’s response I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Non-compliant with Standard 3 Requirement (3)(b). I have provided reasons for my finding in the specific Requirement below.

### 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.*

This Requirement was found to be Non-Compliant following an Assessment Contact conducted on 17 to 18 February 2021 where it was found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of one consumer, specifically in relation to clinical risks associated with nutrition and hydration, infection identification and management, wound/pressure injury management and pain management.

The Assessment Team found the service had implemented several improvements to address the deficiencies identified at the Assessment Contact in February 2021, including (but not limited to):

* Education ‘bootcamps’ for clinical and care staff were conducted which were comprised of significant clinical instruction and training. Clinical staff participated in sessions, including clinical risk and assessment, managing deteriorating consumers, medication management, infection control and continence management. Care staff had training in relation to their roles and responsibilities, including sessions relating to pain management, nutrition and hydration, continence management, infection control, managing deteriorating consumers and reporting.
* Ongoing monitoring of individual high-risk consumers, including the implementation of a ‘resident of the day’ system, a ‘seven-day handover’ process, a ‘daily handover meeting’ with key personnel and a ‘’head to toe’ assessment was completed for all consumers.
* Reintroduction of a high-risk register to provide clinical oversight for consumers identified as ‘high risk’.

While overall, consumers and representatives interviewed were satisfied with management of high impact or high prevalence risks associated with the care of consumers, and noted improvements as outlined above, the Assessment Team found the service was unable to demonstrate consumers’ risk associated with falls management and urinary tract infections were effectively managed. The Assessment Team provided the following information and evidence relevant to my finding:

* One consumer (Consumer A) indicated they did not feel staff know what they are doing in relation to their clinical care needs and felt staff had not acted in timely manner on three occasions in response to their complaints of pain and pulling of the tube associated with blockages of their supra-pubic catheter (SPC).
	+ Progress notes indicate staff did not follow the organisation’s urinary infection policy when two urinalysis results indicated infection.
	+ Progress notes indicate Consumer A complained of pain on 17 May 2021 associated with their SPC. On 19 and 23 May 2021, two urinalysis tests were completed which indicated signs of infection. However, progress notes do not support the medical officer was notified or that additional samples were collected for pathology testing in accordance with the organisation’s policy/procedure.
	+ The consumer indicated to the Assessment Team they were in pain and felt like the SPC was pulling during the Assessment Contact.
	+ Management were unaware of Consumer A’s positive urinalysis results and contacted the medical officer on the first day of the Assessment Contact who commenced the consumer on antibiotics without any further testing. This is not in accordance with the organisation’s policy/procedure.
* Two representatives for one consumer (Consumer B) were not satisfied staff managed the consumer’s high risk of falls by not attending to the consumer’s needs in a timely manner.
	+ The representatives indicated that while care and services had improved, including with staff assisting Consumer B to the toilet in a timely manner, they were still finding used continence aids left in the bathroom on a regular basis and were not satisfied staff were attending to the consumer’s attempts to self-mobilise to the toilet.
	+ Two staff interviewed indicated they were not always able to respond Consumer B’s sensor mat before the consumer would take themselves to the toilet.
* Three consumers’ neurological observations and pain assessments following falls were not completed in accordance with the organisation’s policies and procedures. Two of the three consumers were not provided with assistance/supervision prior to falls in accordance with their care plans.
	+ In relation to Consumer B’s fall on 7 May 2021 which resulted in a fractured hip, the service was unable to demonstrate neurological observations or pain assessments were completed.
		- When the ambulance officers attended following the fall, the consumer required administration of methoxyflurane and opioids to manage pain, but the service was unable to demonstrate the consumer was provided any medications or pain management between the time the consumer had the fall and one-and-a-half hours later when the ambulance officers arrived. A progress note entry following the hospital transfer included limited information in relation to Consumer B’s pain.
		- Management contacted the hospital during the Assessment Contact who confirmed the ambulance officers had administered methoxyflurane which was ineffective and two doses of fentanyl to assist with pain management prior to hospital transfer.
	+ In relation to Consumer C, they had a witnessed fall on 13 May 2021 resulting in a laceration to the nose and forehead, with the incident report investigation indicating the hospital identified a facial bone fracture and right arm fracture. However, the incident reports were conflicting, and one did not indicate if neurological observations were undertaken.
		- While evidence of initial neurological observations was documented, all neurological observations were not provided for the post fall period for this fall.
		- The consumer had a further unwitnessed fall on 18 May 2021, while mobilising to the toilet with no further injuries.
		- Three care staff interviewed indicated Consumer C was independent with mobilising prior to having two falls but the mobility care plan indicated the consumer should be assisted with mobilising prior to these incidents.
	+ In relation to Consumer D, two care staff interviewed indicated the consumer wanders through the corridor but due to staffing levels, it is difficult to maintain supervision. The consumer’s care plan indicates the consumer is for physical assistance for up to 50 metres.
		- Neurological observations were unable to be located on the electronic care system of the first day of the Assessment Contact and the paper-based neurological observations provided on the second day commenced prior to the fall and did not include that neurological observations were taken in accordance with the service’s processes.
		- The incident from investigation states contributing factors include lack of staff supervision.

The Approved Provider submitted a response to the Assessment Team’s report and strongly refutes the Assessment Team’s findings and assert some statements made by the Assessment Team were factually incorrect. The Approved Provider submitted extensive documented evidence to support their assertion that this Requirement should be met. I have considered the Approved Provider’s response which includes corrections/comments to areas of deficiency identified in the Assessment Team’s report. I have considered the following information and evidence from the Approved Provider’s response in coming to my finding:

* In relation to Consumer A:
	+ The urinalysis collected on 19 May 2021, while indicating infection, demonstrates the consumer’s temperature and observations were completed twice that day which indicated they were within normal range and the sample was possibly contaminated. Therefore, it was reasonable that staff did not contact the medical officer.
	+ The urinalysis collected on 23 May 2021, while indicating infection, did not have a sufficient amount of urine collected.
	+ On 25 May 2021, after the Assessment Team alerted clinical staff to the urinalysis results, they contacted the medical officer on the first day of the Assessment Contact, with a urine specimen to be sent to pathology.
	+ On 26 May 2021 pathology results were received and the medical officer was notified.
	+ The Approved Provider asserts that as a result of the Assessment Team questioning the clinical staff as to why a medical officer had not been notified of the two urinalysis results, the medical officer was notified (even though the consumer was asymptomatic and had a SPC). They assert the clinical staff felt coerced into calling the medical officer even though, based on best practice evidence, no abnormality had been detected, clinical assessment had been evident, and the consumer had not displayed any signs or symptoms of an infection on 19 May 2021. Therefore, screening of urinary tract infection was not recommended.
	+ Clinical staff did not notify the medical officer until a clean and non-contaminated specimen was sent to the laboratory. The medical officer was alerted and notified of the second urinalysis on 23 May 2021.
	+ The Approved Provider confirms that the medical officer prescribed antibiotics in response to the clinical staff phone call but is not in accordance with practices supported by the organisation, nor in accordance with antimicrobial stewardship principles.
* In relation to Consumer B:
	+ The Approved Provider asserts the consumer’s falls risk have been effectively managed, with six-monthly physiotherapy reviews and having five falls in four years, with two being near misses.
	+ At the most recent care plan review for Consumer B, the representatives were included and were aware the consumer would not wait for staff to mobilise to the toilet, however, falls preventions strategies were in place. Additionally, the consumer’s continence had declined possibly due to health and assessments indicate the consumer has been incontinent since entry to the service.
	+ In relation to the fall on 7 May 2021, the service contacted the registered nurse from the agency who indicated neurological observations were taken but did not document them.
	+ The Approved Provider assert Consumer B’s pain was managed following the fall on 7 May 2021. The Approved Provider acknowledges documents were not able to be provided on the days of the Assessment Contact but requests from the hospital and ambulance services have been made. The hospital provided documentation and CCTV has been accessed to demonstrate the time of ambulance officers’ arrival and departure with Consumer B.
		- Progress notes indicted Consumer B had a fall at approximately 8.30pm on 7 May 2021. The registered nurse stated they completed an assessment at the time of the fall and noted a skin tear on the consumer’s elbow but no pain was identified, with the consumer able to move all limbs. The consumer was transferred to bed at approximately 9.00pm and complained of right hip pain. After consultation with the representatives, a decision was made to send the consumer to hospital.
		- Consumer B was provided pain relief at 5.45pm on 7 May 2021 and the ambulance officers arrived at 9.18pm (not 10.00pm as stated by the Assessement Team) as evidenced by CCTV and it is reasonable the registered nurse decided not to provide pain relief to the consumer because the ambulance officers had been called. There was only a 15 to 20 minute period when the registered nurse could have administered pain relief, not one-and-a-half hours as stated by the Assessment Team. Additionally, with no orders for non-oral pain medications for this consumer, it is not unreasonable that the registered nurse did not administer pain relief as there may have been a requirement to fast the consumer for potential surgical intervention. On arrival, the ambulance officers administered pain medication and did not transfer to hospital until the consumer’s pain was under control, with CCTV showing the consumer leaving at 10.00pm.
* In relation to Consumer C:
	+ The Approved Provider asserts that Consumer C requires one-person assistance for mobility and this was included their plan of care and the staff interviewed who indicated the consumer was independent with mobility may have had their statements taken out of context or reported incorrectly.
	+ Neurological observations were undertaken immediately following the fall on 13 May 2021 and the consumer was transferred to hospital 20 minutes later and returned approximately three-and-a-half hours from transfer. Discharge information from the hospital and radiology results indicated the consumer had no evidence of head injury or bleeding, therefore, neurological observations were not required to continue to be undertaken in accordance with the organisation’s procedure.
	+ The consumer transferred to hospital following a fall on 18 May 2021 where not further injuries were identified and no evidence of head injury. A progress note indicates the consumer was walking without staff assistance, so a sensor mat was requested.
* In relation to Consumer D:
	+ The Approved Provider does not dispute the level of assistance the consumer requires in relation to mobility but note this part of the assessment related to supervised ambulation indoors and outdoors up to 50 metres. On the night of the fall, the consumer was wandering overnight, was assisted back to bed and 10 minutes later was found walking the corridors following a suspected unwitnessed fall. The Approved Provider asserts that all falls minimisation strategies were in place at the time of the fall but did not prevent the consumer from falling. The Approved Provider asserts the fall was not due to inadequate staffing.
	+ Neurological observations were undertaken initially following the fall but as the consumer was transferred to hospital, and did not return within 24-hours, the need for post falls neurological observations was no longer required.
* Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with this Requirement.
* I acknowledge the Approved Provider’s actions and improvements taken in response to the Non-compliant finding in relation to this Requirement following an Assessment Contact in February 2021, including the strong focus and commitment to educate and train clinical and care staff in relation to relevant aspects of clinical care and follow-up of clinical incidents. However, in coming to my finding I have relied upon evidence which indicates the service has not demonstrated that high impact or high prevalence risks associated with the care of each consumer has been effectively managed. I have addressed my findings in relation to each consumer identified in the Assessment Team’s report and how this relates to the individual management of their high impact or high prevalence risks associated with their care.
* In relation to Consumer A, I find that staff have not effectively managed the consumer’s risk of infection associated with their SPC. While the Approved Provider asserts that staff collected two urinalysis samples which indicated infection, failure to inform the medical officer was reasonable because the consumer’s temperature and observations were within normal range and a clean or sufficient urine specimen had not been obtained. However, I consider the progress note on 17 May 2021 and the Assessment Team’s interview with the consumer indicated the consumer was experiencing pain associated with the SPC, and even though other observations, including temperature were identified as within expected parameters, the signs and complaint of pain (in context of the abnormalities of the urinalysis) should have triggered staff to follow-up in a timelier manner in obtaining an appropriate urine specimen. The service has a procedure for staff to follow in relation to abnormalities detected in urinalysis results to support effective monitoring and follow-up, but staff have not acted in accordance with these instructions. I consider it has taken the service six days from the time of the first urinalysis indicating infection to notify the medical officer who instructed the commencement of antibiotics on notification. The Approved Provider indicated a urine specimen was sent to pathology on the second day of the Assessment Contact, however, have not provided the results of this specimen.
* Additionally, the Approved Provider asserts clinical staff felt coerced into calling the medical officer during the Assessment Contact regarding the urinalysis results even though, based on best practice evidence, clinical assessment had been evident, and the consumer had not displayed any signs or symptoms of an infection on 19 May 2021. Therefore, screening of urinary tract infection was not recommended. However, I consider the consumer’s complaint of pain could be an indication of infection which requires further action and follow-up and that the Assessment Team did not have an opportunity to coerce the medical officer directive to commence antibiotics. It would be reasonable to assume a medical officer would only commence antibiotics in accordance with the consumer’s presenting symptoms and urine sample/pathology results and that clinical staff would consult with the medical officer to ensure antibiotics are prescribed in accordance with antimicrobial stewardship principles and practices.
* In relation to Consumer B, I find the service has managed the consumer’s risk of falls through the implementation of falls prevention strategies. However, I find the service has not effectively managed risks associated with post falls management, including monitoring and assessment of injury and pain following a fall. The service was unable to demonstrate neurological observations or pain assessments were completed following the consumer’s fall on 7 May 2021 which resulted in a fractured hip. While the ambulance officers were called, clinical staff did not document monitoring of pain or neurological observations, or provide pain relief prior to the ambulance officers attending where the ambulance officers, on attendance, provided multiple doses of pain relief prior to transfer to hospital. The Approved Provider acknowledges the registered nurse did not document neurological observations but asserts they were undertaken. They also assert the consumer’s pain was effectively managed following the fall, including that the consumer was administered their routine pain medication approximately two to three hours prior to the fall. Additionally, the Approved Provider asserts it was reasonable for the nurse to not provide pain relief because the ambulance officers had been called and there was only a 15 to 20 minute period when the registered nurse could have administered pain relief. Additionally, the Approved Provider is of the view that with no orders for non-oral pain medications, it is not unreasonable that the registered nurse did not administer pain relief as there may have been a requirement to have the consumer fast for potential surgical intervention. However, I consider the registered nurse should have acted in accordance with the service’s procedures and best practice which is to monitor the consumer for signs and symptoms of pain or injury following a fall, including documenting observations. I have also considered that based on the action of the ambulance officer, that is, administering three separate doses of pain medication to manage the consumer’s pain prior to transfer, indicates the consumer was experiencing significant pain following the fall. While the Approved Provider asserts regular pain relief had already been given and it was reasonable to hold off on providing pain due to the ambulance officers being called and the potential for surgery, I find the regular pain relief was a longer acting medication agent, not specifically prescribed to respond to acute episodes of pain but rather to respond to chronic /long term pain. Additionally, it is not reasonable for a consumer to be withheld pain reliving medication, if it is clinically indicated and will support the consumer to be comfortable. While the Approved Provider asserts there were no non-oral medications prescribed for pain relief and administering this medication may have inhibited surgical intervention, I find at the time the registered nurse did not have knowledge of a fracture nor does the progress note written by the registered nurse support an assessment that they had considered a fracture had occurred. Additionally, the need for surgical intervention would have been unknown and a small amount of water to provide pain relief would not have significantly impacted the scheduling of any required surgery. Therefore, I consider the registered nurse did not manage the consumer’s risk of pain post fall. Based on the evidence presented it appears the consumer was in significant pain based on the actions of the ambulance officers and the registered nurse did not provide pain relieving medication or document their assessment of pain to assist in managing the consumer’s pain.

In relation to Consumer C, I consider the service has demonstrated they have managed risks associated with post falls injury. I have considered that staff undertook neurological observations following a fall on 13 May 2021 and that a hospital transfer quickly transpired following the fall and that neurological injury assessment was undertaken at the hospital which found no evidence of intracranial haemorrhage. While this finding should not negate ongoing monitoring on the consumer’s return the same day, the requirement for actual neurological observations to be conducted has been negated through other investigative measures undertaken to confirm no neurological injury. However, I have considered that staff have not supported the consumer to minimise risk of falls by not having an understanding of the consumer’s care plan which requires the consumer to have one staff assistance with mobility. While the Approved Provider asserts the three staff interviewed who indicated the consumer was independent with mobility may have had their statements taken out of context or reported incorrectly, I have considered that the incident report does not indicate staff were assisting the consumer but rather had observed the consumer to remove their hands from the mobility aid and then lose balance. I consider if staff had been assisting the consumer in accordance with the care plan, it was possible the fall could have been prevented and resulted in the negation of two fractures.

In relation to Consumer D, I find the service has effectively managed risks associated with post falls injury because staff did complete initial neurological observations. A transfer of the consumer to hospital for a period greater than 24-hours resulted in the staff not being required to undertake further neurological observations. While the consumer had a fall while not being assisted by staff with mobility, it appears the service has falls prevention strategies, including a sensor to alert staff when the consumer has moved out of the bed. In relation to this fall’s incident, the evidence does not indicate staff did not act in a timely manner to assist the consumer after they left bed. However, the investigation on the incident from indicates lack of staff supervision as a causative factor and the service should consider efficacy of falls prevention strategies following each incident, including staff responsiveness in the case of Consumer D.

For the reasons detailed above I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Non-Compliant with Standard 3 Requirement (3)(b).

# STANDARD 7 NON-COMPLIANTHuman 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 assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant. Requirements (3)(a) and (3)(c) in this Standard were assessed at this Assessment Contact, all other Requirements were not assessed.

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a) and (3)(c) in this Standard. Requirement (3)(a) was found to be Non-compliant following an Assessment Contact conducted on 17 to 18 February 2021, where it was found the service was unable to demonstrate the workforce has sufficient numbers and skill mix of staff to provide safe and quality care and services.

The Assessment Team have recommended Requirement (3)(a) in this Standard as not met and Requirement (3)(c) as met. The Approved Provider submitted a response to the Assessment Team’s report and have strongly refuted the Assessment Team’s findings in relation to Requirement (3)(a) and provided further information and evidence to support their assertion that this Requirement should be met.

Based on the Assessment Team’s report and the Approved Provider’s response I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Compliant with Requirement (3)(c) and Non-Compliant with Requirement (3)(a) in Standard 7. I have provided reasons for my finding in the specific Requirements 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.*

This Requirement was found to be Non-compliant following an Assessment Contact conducted on 17 to 18 February 2021, where it was found the service was unable to demonstrate the workforce had sufficient numbers and skill mix of staff to provide safe and quality care and services.

The Assessment Team found the service had implemented several improvements to address the deficiencies identified at the Assessment Contact in February 2021, including (but not limited to):

* A consolidated recruitment plan was developed, with a total of 26 new staff commencing employment, including a new residential services manager and clinical services manager. Recruitment processes are ongoing with further clinical and care staff to be employed.
* A staffing model change was made to remove kitchen and food duties from care staff and enrolled nurses. This has resulted in the recruitment of an additional seven hotel services staff members.
* Block-booking of agency staff has been arranged to support continuity of care.
* Call bell monitoring processes have been implemented.
* A comprehensive rostering and staff sufficiency review was undertaken, resulting in development of a range of guidelines, tools and reports to allow for flexibility to respond to consumers’ changing care needs and allocation of the workforce.
* A ‘decision tree’ flow chart has been developed for filling vacant shifts, which includes daily monitoring and reports of unfilled shifts and options to consider when the service is unable to fill the shift.

While the Assessment Team found the organisation has a system for planning and reviewing the workforce model, they found this system was not effective. The Assessment Team provided the following information and evidence relevant to my finding:

* Five of nine consumers/representatives interviewed were not satisfied in relation to staffing levels associated with staff availability to provide assistance in accordance with consumers’ needs and preferences. Additionally, call bell response times indicated four of five of these consumers had call bells in a designated period prior to the Assessment Contact which indicated they were not answered in a timely manner.
	+ Consumer A indicated staff sometimes take too long to empty their urinary catheter bag and will empty it themselves. While the consumer knows they are to wait for staff assistance due to being a high risk of falls, there have been two or three occasions where the bag was too full.
		- Call bell data for Consumer A between 15 April 2021 and 22 May 2021 indicated a total of 202 call bell activations, with six call bells over 10 minutes, and the longest recorded time of 19 minutes.
		- The consumer is reluctant to use their call bell and attempts to not activate the sensor mat, however, the organisation maintains they have balanced the consumer’s right to choose and accept risk with a duty of care.
	+ Representatives for Consumer B were not satisfied staff were attending to the consumer’s continence needs in a timely manner and they were not being assisted to toilet despite being a high falls risk. While the representatives had noted improvements since speaking with management on several occasions, they had observed used continence aids in the bathroom on occasions.
		- Call bell data for Consumer B between 1 and 21 May 2021 indicated a total of 74 call bell activations, with seven calls over 10 minutes and the longest recorded time of 31 minutes.
	+ Consumer C indicated there are not enough staff, and there had not been any improvements with staffing levels. Staff do not always answer the consumer’s call bell in a timely manner to assist with continence needs, resulting in urinary incontinence. The consumer provided an example of the night of 21 May 2021 where they used the call bell, staff did not attend in a timely manner and they subsequently ‘wet the bed’. The consumer indicated they feel ‘terrible’ when they are incontinent due to the additional workload for staff. The consumer is also not always supported to have a shower in accordance with their preference of daily showers.
		- Consumer C’s care plan states the consumer has a preference for daily showers.
		- Call bell data for Consumer C between 1 and 25 May 2021 identified a total of 322 call bell activations, with 25 calls over 10 minutes and the longest recorded time of 23 minutes.
	+ Consumer D informed the Assessment Team their call bell was not working and while the issue had been reported to staff one week prior, it has not been fixed, and contributed to an episode of incontinence. Additionally, when their call bell is working, staff may answer the call bell in a timely manner but turn it off and say they will return (due to the consumer requiring two staff assistance) but they don’t come back.
		- Call bell data for the period 1 to 25 May 2021 identified a total of 89 call bell activations, with nine call bells over 10 minutes and the longest recorded time of 24 minutes.
	+ A representative for Consumer E indicated they have observed a lack of staff, including staff not supporting their consumer with encouragement of fluids when the consumer had two urinary tract infections in the previous month, not enough staff assistance with toileting and has found the consumer ‘wet’ when they visit. While the representative indicated they have raised their concerns, there does not seem to be improvement.
* While management indicated monitoring call bell response times greater than 10 minutes had been a recent improvement, the service did not demonstrate it was effective in identifying issues with call bell responses, including impact to consumers’ care.
	+ Monitoring commenced on 20 and 21 May 2021 with interviews with consumers for call bells greater than 10 minutes being undertaken. Evidence was provided for these days in relation to follow-up with 20 consumers, with overall feedback indicating consumers not recalling having to wait too long, and did not indicate negative impact or concerns. The evidence included an interview with Consumer C who indicated they were happy and did not have to wait that long for staff.
* Eight of 17 care and clinical staff interviewed indicated shifts are not always filled and there are not always enough staff to attend to consumers’ care needs, including answering call bells, attending to consumers’ personal, continence and pressure area care and completing documentation:
	+ Two registered nursing staff and four care staff indicated shifts are not always filled.
	+ Four staff interviewed were able to describe impacts to consumers’ care because of inadequate staffing levels, including not being able to answer call bells in a timely manner, attending to consumers’ toileting needs, personal care and pressure area care.
		- Consumer D requires two staff assistance and reports at times they have been waiting for long time for staff assistance with toileting.
		- Consumer C rings the call bell for assistance to the toilet but sometimes rings when they have already been to the toilet.
		- Rostering, shift allocation documentation and an interview with a staff member who has responsibilities associated with the rostering, indicated shifts are not always filled.
	+ In the week from 18 to 24 May 2021, allocation sheets show there were four of seven days in which shifts were not filled due to care or nursing staff not being available.

The Approved Provider submitted a response to the Assessment Team’s report and strongly refutes the Assessment Team’s findings and assert some statements made by the Assessment Team were factually incorrect. The Approved Provider submitted extensive documented evidence to support their assertion that this Requirement should be met. I have considered the Approved Provider’s response which include corrections/comments to areas of deficiencies identified in the Assessment Team’s report. I have considered the following information and evidence from the Approved Provider’s response relevant to my finding:

* The organisation has had a strong focus on the staffing at this service and since the last Assessment Contact in February 2021 until 10 June 2021 has increased the workforce by 26 employees and an additional four employees following the Assessment Contact in May 2021.
* In relation to specific consumers:
	+ In relation to Consumer A, fluid balance charts demonstrate staff are emptying the consumer’s urinary catheter bag four to six times in accordance with the care plan.
	+ In relation to Consumer B, call bell data indicated seven call bells greater than 10 minutes in May 2021, however, there were no corresponding unfilled shifts.
	+ In relation to Consumer C, there was only one occasion of the consumer’s call bell being answered over 10 minutes, in approximately 12 minutes around 3am. However, correlation of this time did not correspond with any unfilled shifts.
	+ In relation to Consumer D, as soon as management became aware the call bell was not working, the call bell was replaced within an hour and maintenance records indicate the call bell was reported as not working on 11 May 2021 and was found to have a flat battery which was replaced.
		- Call bell data for Consumer D supports there is no correlation to unfilled shifts and call bell response times greater than 10 minutes.
	+ In relation to Consumer E, without any specific dates which the representative is referring to, it is difficult to respond but can confirm staff are allocated in accordance with the organisation’s rostering guidelines and flow charts. The representative was included in a case conference in April 2021 and the clinical services manager has made a time to meet with the representative.
* There have been 14 extra staff onsite during May 2021, including the residential services manager, clinical services manager, acting clinical nurse, nurse advisor, nurse consultant and resident liaison officer.
* The service is running at approximately 84 per cent capacity against the standard roster which is based on 100 per cent capacity. However, no shifts have been cut and additional shifts and supports have been implemented.
* In relation to vacant shifts and reallocation of staff, this is done in accordance with rostering guidelines and considerations and other physical resources, such as management and the nurse advisor can be deployed as required. Where a shift cannot be filled regardless of efforts to do so, there is a reprioritising of responsibilities and duties.
* In relation to staff feedback regarding insufficient staffing, during the period 18 to 24 May 2021, there were a total of 14 extra staff onsite above the standard roster requirements. Changes to hotel services staff will provide additional time for care staff to support consumers. In relation to clinical staff indicating they cannot complete documentation within their allocated shifts, it is difficult to understand these comments without knowing the identity of the staff but will add this topic to future staff meetings for discussion.
* A staff survey has been sent to all staff requesting feedback in relation to the roster and encouragement for suggestions for improvement.
* In the period 18 to 24 May 2021, all shifts were filled on four of the seven days, with any days unfilled having the rostering considerations, guidelines and flowcharts implemented.
* The Approved Provider maintains they have provided sufficient evidence that they are individually addressing call bells responded to which are greater than 10 minutes by going and speaking with consumers. This has included weekly monitoring of call bell data and triangulation of call bell response times greater than 15 minutes against unfilled shifts and individual consumer incidents. Results indicate there is no correlation between delayed call bell responses, unfilled shifts or client incidents.
* With the process commenced of speaking with individual consumers, it is disappointing this large amount of proactive work was not considered adequate by the Assessment Team.
	+ A draft call bell position statement is to be provided to consumers to gain their feedback regarding response time targets for call bells.
	+ The consumer engagement reporting indicated there are no issues with call bell response times.
* The Approved Provider asserts there are no prescriptive components of the Quality Standards which specifies that call bells must be answered within 10 minutes but this seems to be a consistent issue linked with unfilled shifts.
	+ A Site Audit conducted in October 2020 includes in the report an acceptance of a 14-minute key performance indicator for call bells, however, do not understand why call bells continue to be a focus for Assessment Teams.
	+ At assessments of the Approved Provider’s other residential aged care sites, call bell response times have been a significant focus and has resulted in ‘not met’ findings for this Requirement due to call bells being answered in a timeframe greater than 10 minutes. The organisation has stipulated on multiple occasions 10 minutes is not the set response timeframe but is how the data is retried from the call bell system. To address this the Approved Provider has developed a Call Bell Response Position Statement which set specific key performance indictors to meet for all call bell response times.
* Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.
* I acknowledge the Approved Provider’s actions and improvements taken in response to the Non-compliant finding in relation to this Requirement following an Assessment Contact in February 2021, including the strong recruitment focus resulting in a significant number of new employees and commitment to education and training of new and existing employees. However, in coming to my finding I have relied upon evidence which indicates the service has not demonstrated that staff are available to ensure consumers are provided with care in a timely manner or in accordance with their needs and preferences.
* In coming to my finding, I have considered five of nine consumers/representatives have indicated staff do not always assist consumers in a timely manner, which has impacted on consumers’ safety, dignity and comfort. The Approved Provider asserts the Assessment Team have indicated a connection between these consumers’ call bell response times and unfilled shifts. However, the Approved Provider provided further information to support that there were no unfilled shifts during the periods call bells for these consumers were answered in a period greater than 10 minutes. In considering the feedback provided by consumers and representatives, I have not made or considered a connection to unfilled staffing shifts but rather have relied upon the impact consumers/representatives have described in relation to staff not being readily available to assist consumers in a reasonable timeframe, thus indicating the workforce does not enable to delivery and management of safe and quality care and services. In relation to specific consumers:
* I agree with the Approved Provider’s response that there is no direct correlation with call bell response times being greater than 10 minutes and unfilled shifts and acknowledge that new practices and processes have been implemented to support effective rostering and allocation of shifts. However, I have considered the negative outcomes for consumers resulting from staff not being available to assist them or respond to their call bells in time to meet their needs. I have considered that three of the five consumers/representatives indicated consumers have experienced incontinence/being found ‘wet’ either through staff not providing adequate or timely assistance and not answering the call bell, a consumer put themselves at risk due to waiting for staff, a consumer is not support with personal hygiene in accordance with their preferences.
* In addition to the feedback from consumers and representatives, in coming to my finding, I have also relied upon feedback from staff who have indicated there is not always enough staff to attend to consumers’ care needs, including answering call bells, attending to consumers’ personal, continence and pressure area care and completing documentation. While the Approved Provider has provided evidence to support that staffing levels are higher in context of the consumer cohort number and that additional staff have been available during the month of May 2021, I have considered the staff feedback is consistent with some consumers/representatives experiences of care, that is, staff are not always available to provide consumers’ assistance to meet their needs.
* I have also considered that staffing allocation shifts have demonstrated not all shifts are always filled. While the Approved Provider asserts there are rostering guidelines and consideration of additional physical resources available on site, these improvements have not supported that staffing levels are adequate to achieve overall satisfaction from consumers/representative that services delivered are of suitable quality. While I acknowledge and find the service takes action to fill all rostered shifts, there will be occasions where this is not possible and rostering guidelines have been developed to support these instances through a reallocation of duties and responsibilities. However, approximately half of the staff interviewed indicated there are ongoing concerns relating to ability to perform their roles effectively, including being available to provide personal care and answer call bells. The Approved Provider has indicated initiatives and mechanism are being implemented to be better engage with staff, including discussions at staff meetings and staff surveys.
* The Assessment Team have highlighted the number of call bells over 10-minutes in their report for consumers who have indicated call bells and care are not attended to in a timely manner. The Approved Provider had highlighted that the Quality Standards do not stipulate that call bells are to be answered within a 10-minute timeframe but have asserted that new monitoring processes have been implemented to speak with individual consumers who have call bells which are greater than 10-minutes, including contrasting these times with unfilled shifts and incidents. While I acknowledge there is not specified requirement for staff to answer call bells within 10-minutes, the service needs to consider what call bell response timeframe is reasonable for their consumer cohort in relation to meeting their needs and preferences, such as what would be a reasonable expected timeframe to wait for assistance to the toilet. While the Approved Provider has plans to engage consumers in relation to this aspect, this proposal is yet to be presented to consumers. I also acknowledge a new process to follow-up with individual consumers for call bells greater than 10-minutes was implemented five days prior to the Assessment Contact to understand impact for consumers, however, this is a new process which appears to be in the process of being embedded, with evidence for outcomes for consumers provided for two of the five days. I have considered that the consumers identified in this Requirement have had several instances of call bells greater than 10-minutes, some significantly longer than this, but this process has not been embedded to demonstrate efficacy in understanding the consumer experience. While I acknowledge there have been consumer experience surveys and recent follow-up with consumers, there are still a proportion of consumers/representatives interviewed at the time of the Assessment Contact which indicate staffing improvements are still being embedded to improve consumer outcomes.

For the reasons detailed above I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Non-Compliant with Standard 7 Requirement (3)(a).

### Requirement 7(3)(c) Compliant

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

The Assessment Team found the service was able to demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following information and evidence relevant to finding:

* Overall, consumers and representatives interviewed were satisfied staff know what they are doing.
	+ Three of 10 consumers/representatives were not always satisfied staff know how to attend consumers’ care needs, including that staff do not know a consumer’s fluid restriction, not all staff know how to change/empty/position a urinary catheter bag, and staff do not have the ability to obtain a urine specimen.
* Staff interviewed in relation to the consumers/representatives indicated:
	+ The consumer on a fluid restriction does not want to comply with this directive and has signed a risk form to not adhere to this.
	+ In relation to the catheter bags, there are two different bags used and at times agency staff have used the wrong bag, but this issue was identified and has been resolved.
	+ A urinalysis sample was obtained following the representative’s request on two occasions, with no abnormalities identified.
* Staff interviewed confirmed they are provided with ongoing information, education and support to conduct their roles, including that new staff are provided with education during onboarding processes.
* Management described processes used to ensure workforce competency, such as competency assessments following training, clinical audits, review of incidents, weekly risk meetings, observation of staff practices and care assessment and review processes.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service uses recruitment and induction processes to ensure staff who are recruited have the qualifications and knowledge to perform their roles, with onboarding and competency testing processes used to ensure competency for their allocated role. I have also considered that management were able to describe how they support and monitor staff on an ongoing basis. Additionally, overall consumers and representatives are satisfied the staff who attend to consumers’ care and service needs, know what they are doing. While three consumers/representatives indicated some dissatisfaction, clinical and staff were able to demonstrate how concerns with staff competency had been addressed or provided further clarifying information to demonstrate competence.

For the reasons detailed above I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Compliant with Standard 7 Requirement (3)(c).

# STANDARD 8 Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Assessment Team assessed Requirement (3)(d) in this Standard at this Assessment Contact. All other Requirements in this Standard were not assessed.

The Assessment Team have recommended Requirement (3)(d) in this Standard as not met. The Approved Provider submitted a response to the Assessment Team’s report and have strongly refuted the Assessment Team’s findings in relation to Requirement (3)(d) and provided further information and evidence to support their assertion that this Requirement should be met.

Based on the Assessment Team’s report and the Approved Provider’s response I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Compliant with Standard 8 Requirement (3)(d). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) 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 Assessment Team found the service was unable to demonstrate effective risk management systems and practices, specifically related to the management of high impact or high prevalence risks associated with the care of consumers. The Assessment Team provided the following findings and evidence relevant to their recommendation of not met:

* Registered nursing staff have not applied policy and process effectively in the monitoring three consumers post fall, including neurological and general observations and managing a consumer’s potential urinary tract infection.
* The weekly high-risk meetings and register have not been used effectively to monitor consumers at risk for post falls management and potential urinary tract infections.
	+ Investigations into incidents following falls have not been effective in identifying deficiencies, including that staff did not complete neurological observations following a fall for Consumer B on 7 May 2021 and for falls for consumers C and D on 21 April 2021 and 13 May 2021.
	+ The high-risk register does not include Consumer A’s risks associated with their supra pubic catheter.
* Management were unable to demonstrate how incidents are effectively analysed, reviewed or used to reduce risk or improve the quality of care and services.
	+ Incident forms for Consumers B, C and D showed the investigation identified the possible cause or contributing factors but did not demonstrate how this is used to inform continuous improvement.
* Management were unable to demonstrate open disclosure had been used in relation to one incident.

The Approved Provider submitted a response to the Assessment Team’s report and strongly refutes the Assessment Team’s findings and assert the Requirement has not been assessed correctly. The Approved Provider asserts that organisational level governance systems assess and monitor to drive improvement in the quality of care and services and believe the Assessment Team have assessed this Requirement at a local level which is not the intent of the Standard. The Approved Provider submitted the following information and evidence relevant to my finding:

* An organisation-wide risk management system is maintained which includes risks to clinical quality and safety which ensure they are regularly reviewed and used for improvements.
* The organisation has a clinical governance framework to support improvements in the safety and quality of care provide to consumers.
* A dedicated risk register with risk action plans are monitored at the Board level via the Client Care Committee.
* Emerging risks are elevated to the Executive level as soon as they are identified, and the Executive Risk Management Committee maintain a risk issues log which allows for entering of potential risks which do not require immediate attention.
* Reporting structures and systems support escalation of risks or potential risks from site staff to site management, site management to Executive and then to the Board.
* The organisation’s care procedures, guidelines and work instructions are documents based on the best evidence available to instruct clinical and care staff in their care delivery.
* The Approved Provider has processes to identify, respond and manage pain and they had identified an opportunity to strengthen these processes by developing a pain management approach document, which was to be presented to Quality Committee for endorsement on 17 June 2021.
* Appropriate management of incidents identified in the Assessment Team’s report has occurred and Consumer A’s SPC was included on the high risk registered.
* The investigation process for one incident, including the use of open disclosure was in progress at the time of the Assessment Contact and initial open disclosure had been completed.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

Firstly, in coming to my finding, I highlight that this Requirement expects that there are effective risk management systems and practices, including but not limited to management of high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and supporting consumers to live the best life they can. Organisations are expected to have systems and processes to help them identify and assess risks to health, safety and well-being of consumers and that where risks are identified strategies and interventions are used to reduce or remove risks. While the Approved Provider asserts the Assessment Team have incorrectly assessed this Requirement by assessing at a local level, I consider to understand the efficacy of organisational risk management systems and practices, the assessment should include the manifestation of results and outcomes at a local level, which indicates the efficacy of the system and practices of staff to support effective governance. The Approved Provider has submitted in their response as evidence to support a ‘met’ finding that the organisation has reporting structures and systems which support escalation of risks or potential risks which include site staff through the Executive and Board, indicating the importance of staff practices at a local level to support effective risk management.

In coming to my finding in relation to this Assessment Contact, I have considered that both the Assessment Team and the Approved Provider have presented evidence to support the organisation’s risk management framework and overall practices to support effective management of risks. While the Assessment Team have found that registered nurses did not act in accordance with procedures associated with post falls monitoring for three consumers and follow-up of urinalysis results, my findings in Standard 3 Requirement (3)(b) do not support systemic staff practices incongruent with the service’s procedures to minimise risk, but rather more ad hoc instances of staff practices and this evidence has been considered in Standard 3 Personal care and clinical care.

Additionally, while the Assessment Team found incidents have not been used to identify improvements, I consider the evidence presented does not indicate systemic issues with the incident management system. While the Assessment Team found three incidents did find the investigation identified the possible cause or contributing factors, the service did not demonstrate how this is used to inform continuous improvement, I do not consider that evidence presented supports that incidents have not been used to ensure risks to consumers’ safety has been minimised. However, it does present an opportunity for the service to consider how they demonstrate outcomes and actions resulting from individual incident investigations. I consider the service should consider incidents in this Requirement both at an individual, service and organisational level to identify risks and trends to best mitigate any potential risks. I have also considered the service were in the process of using open disclosure processes in relation to the one incident and that the consumer with an SPC had their risks documented on the risk register for ongoing monitoring and consideration.

For the reasons detailed above I find Helping Hand Aged Care Inc, in relation to Helping Hand Aged Care – Lealholme Port Pirie, Compliant with Standard 8 Requirement (3)(d).

# 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.

* **In relation to Standard 3 Requirement (3)(b):**
	+ Ensure clinical staff follow the service’s policies and procedures in response to incidents, specifically falls management and abnormalities associated with urinalysis testing to ensure risks are effectively managed.
	+ Ensure staff assess, monitor and document pain following falls and take actions to reduce or eliminate presenting pain.
	+ Ensure staff use strategies outlined in care plan to minimise risks, including mobility assistance directives and strategies to minimise the risk of falls.
	+ Ensure strategies and interventions used to mitigate and minimise risks associated with care are reviewed for efficacy following consumer incidents.
* **In relation to Standard 7 Requirement (3)(a):**
	+ Ensure there are sufficient staff to meet consumers’ needs and preferences.
	+ Embed improvement processes, including monitoring of consumer outcomes and satisfaction with staffing levels.