Helping Hand Aged Care - Mawson Lakes Facility

Performance Report

2 The Strand
MAWSON LAKES SA 5095
Phone number: 08 8360 2500

**Commission ID:** 6207

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

**Assessment Contact - Site date:** 15 February 2022 to 16 February 2022

**Date of Performance Report:** 17 March 2022

# Performance report prepared by

Janine Renna, 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

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| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(b) | Compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | 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 staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received on 8 March 2022
* the performance report dated 28 September 2021 for the Assessment Contact conducted on 12 August 2021
* the performance report dated 7 May 2021 for the Site Audit conducted on 23 February 2021 to 25 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 Requirement has been assessed as non-compliant. The Assessment Team assessed Requirement (3)(b) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found non-compliant following an Assessment Contact conducted on 12 August 2021 where it was found high impact or high prevalence risks, specifically in relation to skin integrity and wounds, were not effectively managed for each consumer. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact.

The Assessment Team recommended the service did not meet Requirement (3)(b) in this Standard. The Assessment Team was not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer in relation to wounds, pressure area care and diabetes.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and I find the service non‑compliant with Requirement (3)(b). I have provided reasons for my findings under 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 non-compliant following an Assessment Contact conducted on 12 August 2021, as the service was unable to demonstrate wounds and changes to skin integrity were identified in a timely manner and effectively managed. The Assessment Team’s report for the Assessment Contact conducted on 15 February 2022 to 16 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Training and education has been provided to staff in relation to wound charting.
* The wound chart audit tool was upgraded and staff compliance has been audited.
* Policies and procedures have been reviewed and updated.

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

Wound management

Consumer A

* Documentation showed in December 2021, the consumer’s pressure injury risk had been assessed as severe, however, a repositioning chart was not commenced at the time of the skin assessment or following identification of the consumer’s pressure injury.
* Despite the consumer being identified as at severe risk of pressure injuries, management confirmed the only pressure relieving devices considered were a cushion and pressure relieving chair.
* Following the consumer’s pressure injury risk assessment of severe risk, the consumer’s care plan was reviewed and did not identify any skin integrity issues.
* Documentation demonstrated in January 2022, a stage two pressure injury was identified on the consumer’s sacrum, however, a repositioning chart was not commenced.

Consumer B

* The consumer’s skin assessment indicates they are at high risk of developing pressure injuries.
* During September 2021, a repositioning chart was commenced and preventative strategies implemented, which included three to four hourly repositioning and daily check of heels and sacrum.
* Documentation demonstrated a stage two pressure injury was identified on the consumer’s sacrum in January 2022.
* Wound treatment documentation included four photographs of the consumer’s wound that were taken from difficult angles and did not clearly show the size.
* In the seven days following identification, documentation showed the stage two pressure injury was healing and was downgraded to a stage one, however, the wound size has not changed since this time.

 Consumer C

* Documentation demonstrated the consumer had three pressure injuries, which included both stage one and stage two.
* The wounds were photographed at different angles, making comparison of the wounds difficult.
* Documentation and interviews with management demonstrated the three wounds were measured as a whole, not separately, and the status of each individual wound was not documented to monitor if the three wounds were deteriorating or healing.
* The organisation’s procedure in relation to wound and skin care requires staff to commence a wound chart for each wound.

Diabetes management

* Documentation showed Consumer D has type two insulin dependent diabetes and is prescribed regular insulin four times a day and as required sliding scale insulin when their BGLs exceed a specified level.
* Documentation for a sampled period shows on seven occasions, the consumer’s BGLs were outside the reportable range and the medical officer was not notified, in line with directives.
	+ Documentation showed on one occasion, the consumer did not receive as required medication when their BGL exceeded the specified level, as per medical officer directives. On this occasion, the consumers BGL was out of range for a period of 18 hours.

Medication management

* Documentation showed as required psychotropic medication is administered to three consumers for the purpose of altering their behaviour, including resistance to care and aggression.
* The service did not recognise the three consumers were being chemically restrained.
* For one of three sampled consumers, consent was not documented and a behaviour support plan was not in place. Documentation showed verbal consent was obtained from the representative 15 days after it had been prescribed.

While some deficits identified by the Assessment Team were acknowledged, the provider asserts they are not representative of the experience for all consumers. The provider’s response includes the following information and evidence to refute assertions made by the Assessment Team:

Wound management

* The organisation’s Maintaining skin integrity procedure to demonstrate repositioning charts are not required to be commenced following identification of a change in skin integrity.
	+ The procedure provided is not dated to evidence that it was in place at the time of the Assessment Contact.
	+ The procedure requires staff to observe consumers’ skin daily when attending to personal care and report any anomalies or compromised skin integrity to the supervising nurse.
* In relation to Consumer A:
	+ Three skin assessments for the period 27 October 2021 to 24 December 2021 demonstrating preventative strategies were reviewed and changed in response to Consumer A’s increased risk of pressure injuries.
	+ Care planning documentation to demonstrate their care plan was updated in line with their skin assessment. Care planning documentation following identification of the pressure injury was not provided.
	+ Acknowledgement that wound photographs were of poor quality. The provider’s response explains that wound photographs, assessments, charting and progress notes are used collectively to determine the overall state and stage of wounds.
	+ Wound management report demonstrating Consumer A’s wound had resolved prior to the Assessment Contact.
* In relation to Consumer B:
	+ Acknowledgement that the length and width of the wound are not recorded on the tape measure, however, these measurements are recorded on the wound chart.
* In relation to Consumer C:
	+ It was appropriate to classify the affected area as one wound, as pressure areas are not just confined to the areas of broken skin but extended to any areas in which the skin integrity is compromised.

Diabetes management

* Evidence demonstrating the medical officer was notified on one of the seven occasions.

Medication management

* The use of psychotropic medication for one of three consumers is believed to be for anxiety not for the purpose of altering behaviour. In relation to the remaining two consumers, it was used as an ‘emergency’ as staff and other consumers were at risk.

The provider’s response includes actions taken to address deficiencies identified by the Assessment Team, including but not limited to, conducting fortnightly wound documentation audits, staff education and training in relation to skin, wound and diabetes management, and replacement of equipment used to photograph wounds.

I acknowledge actions taken by the service to rectify issues identified by the Assessment Team, however, I find at the time of the Assessment Contact, high impact or high prevalence risks associated with the care of each consumer were not effectively managed.

In coming to my finding, I have considered preventative strategies to minimise the risk of pressure injuries were not effective, as three consumers developed pressure injuries despite being assessed at high or severe risk. Additionally, the organisation’s procedure requires staff to observe consumers’ skin daily, however, two consumers’ pressure injuries were not identified until they had deteriorated to stage two.

In relation to consumer A, while staff did not implement a repositioning chart following an assessment of severe risk or development of a stage two pressure injury, there is no evidence indicating they were not being repositioned in line with their care plan.

In relation to one consumer with diabetes, I have considered that staff did not notify the medical officer on six occasions when their BGLs were out of range and on one occasion, the consumer did not receive as required medication when their BGL exceeded the specified range, as per medical officer directives. On this occasion, the consumers BGL was out of range for a period of 18 hours.

In relation to medication management, I have considered the evidence provided is more aligned with Requirement (3)(e) in Standard 8 Organisational governance, which was not assessed at the Assessment Contact.

Based on the evidence summarised above, I find the service non-compliant with Requirement (3)(b) 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)(b) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021 where it was found the service did not demonstrate services and supports for daily living promoted each consumer’s emotional and psychological well-being. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service meets Requirement (3)(b) in this Standard. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(b). I have provided reasons for my findings under the specific Requirement below.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021, as the service was unable to demonstrate services and supports for daily living promoted each consumer’s emotional and psychological well-being. Consumers and representatives reported consumers’ emotional needs were not being met and staff said they did not have time to spend with consumers to meet their emotional needs. The Assessment Team’s report for the Assessment Contact conducted on 15 February 2022 to 16 February 2022 provides evidence of actions taken in response to the non-compliance, including:

* Increasing the volume of staff and providing additional support.
* Reviewing and updating care plans.
* Obtaining consumer feedback in relation to the lifestyle program and the impact on their emotional, spiritual and psychological well-being.
* Implementation of a register to record consumers with diverse needs and characteristics.

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:

* Prior to the Assessment Contact, the service had ended an extended period of lockdown due to an outbreak of coronavirus (COVID-19).
* Consumers and representatives provided examples of how consumers’ emotional and psychological needs have been met, including during the recent lockdown.
* Documentation showed one consumer had been identified as needing emotional and psychological support and in response, they were monitored and provided support through both internal and external support services.
* Staff provided examples of support provided to consumers throughout the recent lockdown, including one-to-one engagement, arranging partnerships in care, online church services, exercise sessions, contacting families, implementing ‘happy hour’, celebrating birthdays and engaging Dementia Support Australia (DSA).
* Documentation showed DSA has reviewed all consumers residing in one area of the service, and strategies have been implemented to increase staff engagement and promote consumers’ psychological well-being.
* Management reported the service has entered into an agreement with Relationships Australia and Well-being for the provision of psychological therapy and support for consumers.
* Posters were observed on consumers’ doors, which included information in relation to their life history and spiritual needs.
* High risk residents’ meetings discuss consumers with low mood, including identification and evaluation of management strategies.

The provider’s response did not address the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(b) in Standard 4 Services and supports for daily living.

# STANDARD 5 Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team assessed Requirement (3)(b) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021 where it was found the service did not demonstrate the environment was safe and enabled consumers to move freely, both indoors and outdoors. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service meets Requirement (3)(b) in this Standard. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(b). I have provided reasons for my findings under the specific Requirement below.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021, as the service was unable to demonstrate consumers were supported to move freely within the service environment. Specifically, the Assessment Team found doors to courtyard areas were locked and prevented consumers from accessing these areas with ease, and observations of the service environment identified risks were not consistently identified and managed. The Assessment Team’s report for the Assessment Contact conducted on 15 February 2022 to 16 February 2022 provides evidence of actions taken in response to the non-compliance, including:

* Installation of automatic timers to internal courtyard doors and education provided to staff of the importance of consumers having free movement.
* Clear signage for doors leading to internal courtyards and gardens indicating the summer and winter timeframes for access.
* Monthly audits have been undertaken on all hot water drink systems to ensure safety locking mechanisms.

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 were satisfied with the service environment and considered it to be safe, clean and well-maintained.
* Staff described how they ensure the environment is safe and well-maintained, including the process for undertaking preventative and reactive maintenance.
* The environment was observed to be well-maintained, clean, tidy and odour free.
* While automatic door locks were observed on courtyard access points, summer and winter access timeframes were clearly signed and included instructions to speak to staff if consumers wished to access the area outside of these times.
* Consumers were observed moving freely outside in the courtyards and gardens spaces.
* Documentation demonstrated there were no outstanding maintenance tasks.

The provider’s response did not address the Assessment Team’s findings in relation to this Requirement.

Based on the evidence summarised above, I find the service compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# STANDARD 7 Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in this Standard. This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021 where it was found the service did not demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and effective care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service meets Requirement (3)(a) in this Standard. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(a). I have provided reasons for my findings under the specific Requirement 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.*

This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021, as the service was unable to demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services. Specifically, consumers, representatives and staff considered staffing numbers to be insufficient and provided examples of how consumers’ care and services were impacted. The Assessment Team’s report for the Assessment Contact conducted on 15 February 2022 to 16 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Undertaking recruitment of permanent staff and utilising agency staff to backfill unplanned leave.
* Monthly roster reviews have been untaken and have resulted in increased staffing hours across the site.
* The roster is monitored on an ongoing basis and Staff sufficiency assessments are being undertaken quarterly to ensure staffing adequacy across the site.
* Organisational procedures relating to call bell response times and staff position statements have been updated.
* A new call bell reporting system has been implemented allowing data to be extracted and reviewed more efficiently.

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

* Overall, consumers and representatives said consumer care needs are met and call bells are responded to in a timely manner.
* Most staff reported there are enough staff rostered each day to allow them to undertake their duties and attend to consumers’ needs in a timely manner.
* Management reported the service uses a Staff sufficiency assessment to monitor staffing numbers. The assessment includes a review of call bell response times, incidents, consumer acuity, complaints, casual staff pool, continence needs and behaviour management. Management also reported a centralised rostering team has been created, which is responsible for managing replacement staff for unfilled shifts.
* Management provided an example of when changes to rostering occurred in response to a consumer with increased behaviours.
* Feedback logs for a 15 week sampled period showed two complaints in relation to staff shortages. These complaints were reviewed, investigated and closed.
* Rosters for a 15 day sampled period demonstrated 11 unfilled shifts.
* Call bell data for a four month period shows the service’s key performance indicators are being met.

The provider’s response did not address the Assessment Team’s findings in relation to this Requirement.

Based on the evidence summarised above, I find the service compliant with Requirement (3)(a) in Standard 7 Human resources.

# 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)(c) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in this Standard. This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021 where it was found the service did not demonstrate workforce governance systems were effective, as workforce shortages had not been identified and addressed. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service meets Requirement (3)(c) in this Standard. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(c). I have provided reasons for my findings under the specific Requirement 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.*

This Requirement was found non-compliant following a Site Audit conducted on 23 February 2021 to 25 February 2021, as the service was unable to demonstrate workforce governance effectively ensured sufficient staff were available to consistently deliver quality care and services. Consumers and representatives reported dissatisfaction with staff availability and responsiveness and provided examples of how consumers’ health and well-being had been impacted negatively. The Assessment Team’s report for the Assessment Contact conducted on 15 February 2022 to 16 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* An organisational rostering system has been implemented to facilitate improved rostering capability in regard to scheduling and management of unfilled shifts.
* A learning and development manager and four clinical educator positions have been recruited across the organisation to provide onsite support, training and mentoring to clinical and care staff.

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

* Interviews with management and staff demonstrated staff have access to the information they need, through various means, to deliver care and services to consumers. Representatives said they receive regular communication regarding their family member.
* The organisation has a Continuous improvement plan, which is informed by consumer, representative and staff feedback, clinical data analysis, incidents and complaints data.
* Management explained the process for ascertaining approval for out of budget or expenditure requests.
* Interviews with management and documentation demonstrates systems are in place to monitor and report workforce numbers, competency and performance. The organisation has policies and procedures in place to support staff practice and staff are aware of their responsibilities and accountabilities through position descriptions and duty statements.
* The organisation has a quality team, who manages and reviews legislative changes for the organisation and communicates updates to the necessary departments, consumers, representatives and staff as required through various channels. The organisation tracks changes to regulatory responsibilities through subscriptions to peak bodies and government updates.
* Feedback and complaints processes are in place to ensure they are monitored to identify trends and areas for improvement.

The provider’s response did not address the Assessment Team’s findings in relation to this Requirement.

Based on the evidence summarised above, I find the service compliant with Requirement (3)(c) 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.

* Ensure staff have the skills and knowledge to:
* Recognise changes to consumers’ skin integrity, take appropriate action and implement management strategies.
* Provide appropriate care relating to wound and diabetes management.
* Ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wound management and diabetes management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wound management and diabetes management.