John Paul II Village

Performance Report

6A Dianne Street   
KLEMZIG SA 5087  
Phone number: 08 8369 0377

**Commission ID:** 6125

**Provider name:** Southern Cross Care (SA, NT & VIC) Inc.

**Assessment Contact - Site date:** 1 January 2021

**Date of Performance Report:** 2 April 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(g) | 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 20 January 2021.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

To understand the consumer’s experience and how the organisation understands and applies the Requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Overall sampled consumers considered that they receive personal care and clinical care that is safe and right for them.

For example:

* Two consumers interviewed said staff are aware of their needs and take good care of them. They gave examples including being aware of their dietary needs and the management of their pain.
* One consumer reported they had very itchy and dry legs. They claimed staff “don’t give a damn” and don’t apply creams daily as required. However, the Assessment Team did not find evidence to support this.
* One representative said overall the staff take very good care of their family member but some of the newer/younger staff need further training in the delivery of personal care. They said these staff do not always attend fully to personal care such as wiping soap off consumers faces and drying groin skin folds properly when changing continence aids.

Two consumers and a representative interviewed said consumers can see a doctor any time they need to. If their doctor is not available a locum can be called instead.

The Assessment Team found the service could not demonstrate deterioration or a change in a consumer’s physical function, capacity or condition had been recognised and responded to in a timely manner.

The Assessment Team viewed care documentation for sampled consumers and found that whilst staff had followed falls management procedures in line with service policy, they had failed to recognise recurrent high blood pressure readings and respond in accordance with the service’s rapid detection and response procedure.

The Assessment Team viewed care files for sampled consumers and found the service was unable to demonstrate effective management of high-impact and high-prevalence risks associated with the care of each consumer in relation to pain management.

Care documentation viewed demonstrated current pain strategies were not reflected in care plans, pain charting had not been commenced following increased behaviours and worsening existing pain and strategies had been ineffective at preventing and managing ongoing pain.

The Assessment Team observed some breaches in infection control practices and an inadequate supply of personal protective equipment available to staff for a consumer in isolation. However, the service was able to demonstrate it had minimised infection related risks for one consumer and had appropriate processes and practices in place for minimising infection-related risks.

The Quality Standard is assessed as Non-compliant as two of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

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

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

The Assessment Team found that Care planning documentation illustrated sampled consumers had been assessed for high-impact and high-prevalence risk on entry to the service, at six monthly care plan reviews and when health needs had changed. Validated risk assessments had been used to inform service delivery and were reflected in care plans. These were reviewed following an incident, such as a fall and at six monthly care plan reviews.

The Assessment Team noted that where high impact and high prevalence risk were identified, such as challenging behaviours and increased likelihood of falls, staff had implemented strategies, initiated neurological charting, evaluated the effectiveness of interventions and instigated referrals to MO’s and Allied Health professionals when appropriate.

However, the Assessment Team report described how review of care documentation and policy’s and, discussion with consumers, representatives and staff, confirmed that the service was unable to demonstrate effective management of high-impact and high-prevalence risks associated with the care of each consumer in relation to pain management. The Assessment Team’s report described examples of sampled consumers for whom pain management was not effective. They described ineffective assessment and monitoring of consumer’s pain and an inability to identify triggers and causes of pain.

While the service has processes, such as 24-hour progress note reviews and weekly risk review meetings to manage and monitor risks related to the personal and clinical care of each consumer, in addition to policies and procedures to guide staff practice, the service could not demonstrate each sampled consumer’s pain had been managed effectively or assessed in a timely manner.

In their response, the Approved Provider submitted information about issues raised by the Assessment Team. The summary table described, and attachments confirmed that actions have been taken since the Assessment Contact. These include case conferences, review of pain management domain for all consumers, interviews with consumers and representatives to establish level of satisfaction regarding pain management. They have also undertaken updates to handover processes, Work Instructions, high risk resident procedures, nonverbal pain monitoring templates and delivered education to staff about new processes and templates and correct documentation of pain ratings pre and post pharmacological interventions. They have assessed pain management competency for all Registered and Enrolled nurses. While many of these activities had been completed at the time of the response submission they described how process improvement will be systematically rolled out and additional training completed at a time in the future.

While the Approved Provider has responded constructively to feedback from the Commission and confirmed that activities are under way to address the gaps identified by the Assessment Team since the Assessment Contact, I am not satisfied that this confirms that they were compliant at the time of assessment. The Approved Provider also needs time to demonstrate that the actions taken have resulted in sustained improvements in pain management.

I am of the view that the Approved Provider does not comply with this requirement as it did not adequately demonstrate that they effectively managed the high impact and high prevalence risks of each consumer in relation to pain management at the time of the Assessment Contact.

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

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

The Assessment Team’s report described an example from their review of sampled consumer’s care documentation and policies and interviews with staff and management. They observed that whilst staff had followed falls management procedures in line with service policy, they had failed to recognise recurrent high blood pressure readings and respond in accordance with the service’s rapid detection and response procedure. Management reported they have monitoring processes, including 24-hour progress note reviews and weekly risk review meetings, for ensuring appropriate and timely action is taken in response to deterioration or a change in health status. Meeting minutes of four risk review meetings viewed, demonstrated that a sampled consumer had been identified in response to a missing Norspan patch and falls, however, there was no mention of hypertension.

In their response the Approved Provider submitted information about the issues identified by the Assessment Team. The summary table described, and attachments confirmed that actions have been taken since the Assessment Contact. These include review of the practice of the nurse who did not follow the service’s documented guidance about rapid detection and response. They have also consulted the GP about individualised clinical parameters and updated case notes and communicated changes to staff. Actions associated with the compliance finding in Requirement 3(3)b relate to this requirement with respect of a review of the High-Risk Resident Procedure and associated staff training.

While the Approved Provider has responded constructively to feedback from the Commission and confirmed that activities are under way to address the gaps identified by the Assessment Team since the Assessment Contact, I am not satisfied that this confirms that they were compliant at the time of assessment. The Approved Provider also needs time to demonstrate that the actions taken have resulted in sustained systemic improvements in recognising and responding to deterioration.

I am of the view that the Approved Provider does not comply with this requirement as it did not adequately demonstrate that they effectively recognised and responded to deterioration or change in a consumers condition at the time of the Assessment Contact.

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission-based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# 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.

### Requirement 3(3)(b)

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

The Approved provider must demonstrate that:

* The actions described in their plan for continuous improvement have been completed in relation to the identification, monitoring and evaluation of pain; and
* There has been a measurable improvement in clinical outcomes associated with pain management following the implementation of actions since the Assessment Contact, which has been sustained.

### Requirement 3(3)(d)

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

The Approved provider must demonstrate that:

* The actions described in their plan for continuous improvement have been completed in relation to recognising and responding to deterioration of consumer’s condition; and
* All staff are aware of and apply the service policies in relation to recognising and responding to deterioration.