LHI Hope Valley

Performance Report

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**Commission ID:** 6134

**Provider name:** Lutheran Homes Inc

**Assessment Contact - Site date:** 7 July 2020

**Date of Performance Report:** 17 August 2020

# 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

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| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(f) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 31 July 2020.

# 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. The Assessment Team assessed Requirements (3)(b) and (3)(f) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(b) and (3)(f) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted 15 January 2020 to 17 January 2020.

The Assessment Team assessed Requirement 3(b) in relation to Standard 3. Whilst the service has made some improvements in response to the Non-compliance identified at the Site Audit, the Assessment Team were not satisfied the service adequately demonstrated effective management of high impact or high prevalent risks, specifically in relation to behaviours, oxygen therapy, pain and nutrition for one consumer. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 Requirement (3)(b) and find the service does not comply with Requirement (3)(b). I have provided reasons for my decision in the specific Requirement.

At a Site Audit conducted 15 January 2020 to 17 January 2020, in relation to Standard 3 Requirement (3)(f), the Decision Maker found, in relation to two consumers who had weight loss, the service did not respond appropriately or promptly in relation to the consumers’ changing needs in line with their processes. In relation to Requirement (3)(f), the service has implemented a range of actions to address the deficiencies identified which I have detailed 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.*

The organisation has processes to manage risks in relation to clinical incidents, including challenging behaviours and clinical risks, such as nutrition and pain. However, the Assessment Team found these processes have not been consistently or effectively implemented to minimise risks to other consumers posed by one consumer’s behaviours. This was evidenced by the following:

* Progress notes describe two incidents, 30 June and 5 July 2020, of the consumer giving food to other consumers who are on texture modified diets and at risk of choking.
* Staff interviewed said they were aware the consumer gives food to other consumers, including those at risk of choking. Staff said they watch the consumer as time permits.
* The consumer’s continuous behaviour chart does not include any entries relating to the consumer placing other consumers at risk by providing them food.
* Potential for the behaviour to occur and interventions or strategies to manage these behaviours to ensure other consumers are safe are not included on the consumer’s behaviour care plan.
* The Clinical coordinator was not aware of the incident on 30 June 2020 and an incident form had not been completed.
* Management stated the incident on 5 July 2020 occurred whilst they were not at the service and, therefore, no risk management strategies would be developed until their return to work later in the week.

The approved provider’s response indicated they agreed with the Assessment Team’s findings relating the incidents and the lack of information available to staff to guide care and services and ensure the safety of other consumers. The approved provider’s response demonstrates the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and have implemented the following actions:

* Behaviour charting for the consumer has been reviewed and a comprehensive behaviour care plan developed. Appropriate behaviour management strategies have been implemented to minimise risk to other consumers.
* 24-hour progress note review by management and Coordinators has been implemented. This will ensure incidents are identified and investigated.
* Review of daily 10 at 10 catch-up meeting processes to include discussions relating to high risk progress note entries and issues identified during the shift.
* Reminders to staff relating to completion of incident forms.

The Assessment Team were not satisfied comprehensive care plans to provide safe and effective pain management and nutritional support were in place for this consumer. This was evidenced by the following:

* Clinical assessments and care plans have not been completed for the consumer to assist staff to provide care and services in line with the organisation’s Standard operating procedure (SOP).
* Pain charting documentation demonstrated both verbal and non-verbal indicators of pain, however, a pain assessment has not been completed or a care plan implemented to assist staff to respond to the consumer’s pain needs.
* A malnutrition screening tool indicates the consumer is at moderate risk of malnutrition. However, a nutritional assessment has not been completed or a care plan developed to minimise risks to the consumer.

The approved provider’s response indicated they did not agree with the Assessment Team’s findings relating to the consumer’s assessments and care plan not being completed in line with the organisation’s SOP. The response indicates the consumer was a respite admission and did not have detailed, comprehensive care plans in place. The SOP does not require full care planning until week eight and, therefore, the consumer was within the review timeframes. The approved provider’s response demonstrates whilst they did not agree with the findings, the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and have implemented the following actions:

* Reviewed the Care plan development and evaluation SOP and Resident admission risk assessment checklist. Changes will ensure consumers admitted with high risk care needs are comprehensively assessed and detailed care plans and management strategies are developed in a timely manner.
* The consumer has been comprehensively assessed in relation to cardiovascular – respiratory, pain, behaviour, dietary and sleep. Additionally, a full comprehensive nutritional care plan has been developed.
* Care coordinator to oversee development of care plans following completion of clinical charting.
* High risk areas for new admissions and respite consumers will be fully assessed shortly after admission.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit conducted 15 January 2020 to 17 January 2020. The Assessment Team’s report outlined the following actions and improvements implemented, including:

* Organisational SOPs have been reviewed and updated, for example:
* Medication management SOP changes include monitoring of medication incidents, follow up with staff when required and weekly audits. Clinical staff were notified of changes in February 2020.
* Altered nutrition SOP changes reflect the policy and guide staff to refer consumers with unplanned weight loss and for staff to commence consumers on milkshakes if weight loss is over two kilograms. Clinical staff were notified of changes in March 2020.
* Organisational pain assessment tools have been reviewed and implemented, for example:
* Abbey pain scale has been reviewed to provide clearer guidance to staff and includes a matrix for pain score and severity. Education and information on the use of the assessment tool was provided to staff in February and March 2020.
* Commenced a trial of an electronic pain check application in June 2020. Staff have been provided education in relation to the use of the application which is currently being used to assess pain for consumer unable to verbalise pain.
* A medication incident monitoring spreadsheet is maintained to enable identification of trends. Management advised an increase in incidents due to staff documentation and monitoring was noted. However, the number of medications being given late has decreased.
* An unplanned weight loss spreadsheet is maintained and consumers who have lost weight in line with the SOP criteria are reviewed weekly at the Health and Well-being meeting.
* Pain audits are conducted six-monthly and include consumer interviews and a pain assessment.
* Twenty staff completed a medication administration competency in June 2020. The service will complement the competency with on-site training and supervision of medication administration during the initial process.
* Eleven Enrolled and Registered nursing staff completed Chronic pain education in March 2020.

While I acknowledge the approved provider’s proactive response to the Assessment Team’s findings, I find that at the time of the Assessment Contact the service was not effectively managing the behaviours of one consumer which were putting other consumers at risk. Staff interviewed by the Assessment Team were aware of the consumer’s behaviours and the risk they posed to others. A care plan outlining the management strategies to mitigate potential risks posed by the consumer’s behaviour was not in place to guide staff with provision of care. Senior clinical staff were not aware of the incident which occurred on 30 June 2020. Furthermore, risk management strategies were not developed following the incident on 5 July 2020 as Management were on not at the service at the time and, therefore, would not be actioned until their return to work.

I also find, whilst the consumer was residing at the service on a respite basis, appropriate assessments had not been completed or care plans generated to address the consumer’s pain or nutritional requirements.

For the reasons detailed above, I find the approved provider, in relation to LHI Hope Valley does not comply with Requirement (3)(b) in Standard 3.

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

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Consumers are weighed monthly. Consumers with unplanned weight loss are reviewed weekly at the Health and Well-being Clinical meetings. Actions taken in response to weight loss include referral to Dietitians and/or Medical officers.
* An alternate Dietetic service provider has been identified and is available for referrals when the primary Dietitian is unavailable.

In relation to Standard 3 Requirement (3)(f), documentation viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

Representatives interviewed confirmed consumers have access to other health professionals and staff initiate referrals and facilitate appointments.

Staff interviewed stated referrals are discussed daily at handover in consultation with senior clinical staff. Clinical staff described how consumer referrals are identified and initiated, including following falls, weight loss and identification of swallowing difficulties.

Consumer files viewed by the Assessment Team included evidence of referral to and review by Medical officers and various Allied health professionals.

The organisation has monitoring processes in relation to Standard 3 Requirement (3)(f) to ensure timely and appropriate referrals of consumers to providers of other care and services.

For the reasons detailed above, I find the approved provider, in relation to LHI Hope Valley does comply with Requirement (3)(f) in Standard 3.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant. The Assessment Team assessed Requirement (3)(c) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The Assessment Team found the organisation did not adequately demonstrate understanding of legislative requirements relating to reporting incidents of alleged abuse to consumers.

The Assessment Team recommended Requirement (3)(c) in Standard 8 as not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service does not comply with Requirement (3)(c). I have provided reasons for my decision in the specific Requirement.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The Assessment Team found the organisation did not adequately demonstrate understanding of legislative requirements relating to reporting incidents of alleged abuse to consumers. This was evidenced by the following:

* A consumer representative made a formal complaint on 31 May 2020 indicating an incident of alleged abuse against a consumer by a staff member.
* Management conducted an internal investigation on 31 May 2020 which included interviews with the consumer, representative and staff. An Investigation outcome letter to one of the staff members dated 9 June 2020 indicated the allegations were substantiated. The letter outlined a breach relating to dignity and respect and not following the consumer’s care plan.
* Management felt the incident was not excessive use of force or assault and, therefore, the incident was not required to be reported in line with their understanding of compulsory reporting legislation.
* Management are aware of reporting obligations and timeframes and stated they took several steps to ensure all bases were covered to meet requirements. However, in this instance, management did not feel the incident met the criteria. Management stated the incident related to staff not listening to the consumer and not being mindful of their concerns relating to their care plan needs.

The approved provider’s response indicated they do not dispute the Assessment Team’s findings and, following review of the details of the incident, they acknowledge the incident should have been reported in line with compulsory reporting requirements. Additionally, the approved provider’s response indicates the management team acknowledges an error of judgement was made in relation to this incident. The approved provider stated the Assessment Team’s finding is not systemic and is an isolated case. In response to the Assessment Team’s report, the approved provider has implemented the following actions:

* Reviewed and updated policies and procedures related to compulsory reporting. Additionally, an extra clause has been added indicating all incidents of a suspected mandatory report are to be escalated to the Chief executive officer for review and final decision.
* The new policies and procedures have been provided to all staff. Staff are to indicate they have read and understood the documents by end of August 2020.
* Training for all staff in relation to Mandatory reporting and Elder abuse is in progress. All staff are expected to have completed the training by end of August 2020.
* Implementation of 24-hour progress note review by management. The report will be analysed by a manager and uncaptured incidents, complaints or risk areas are to be flagged and followed up at a management level.
* The organisation has developed a tool box for Managers which includes extracts from the Aged Care Act and compulsory reporting flowcharts to remind staff of decision-making processes and guidance material available when assessing a compulsory report.
* A general staff meeting in August 2020 will include explanation of the process for investigation of compulsory reports.
* The organisation has reviewed complaint management processes. Complaints deemed high risk are to be escalated to the Chief executive officer. Complaints policies and procedures have been updated to reflect the change in process.
* The Agency handbook has been reviewed to strengthen references to reporting of mandatory incidents.

I acknowledge the approved provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on my review of the Assessment Team’s report and approved provider’s response, I am satisfied the service does not comply with this Requirement. Whilst the incident was investigated, the incident was not identified as a reportable incident or managed in line with legislative requirements. Additionally, the Assessment Team identified the incident as a reportable incident on the day of the Assessment Contact on 7 July 2020, two months after the incident. The service then did not report the incident to the Commission or the Police until 21 July 2020, 14 days after the visit.

For the reasons detailed above, I find the approved provider, in relation to LHI Hope Valley does not comply with Requirement (3)(c) in Standard 8.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

Standard 3 Requirement (3)(b):

* Ensure appropriate charting and assessments are completed for all consumers, both permanent and respite, to identify high prevalent or high impact risks relating to the care of each consumer.
* Ensure comprehensive care plans are developed for consumers which include appropriate management strategies to assist staff to deliver care and services in line with consumers’ assessed needs.
* Ensure staff have the skills and knowledge to escalate/report incidents, including in relation to challenging behaviours and behaviours which pose a risk to other consumers.
* Ensure senior Clinical staff have the skills and knowledge to follow up incidents and review and/or implement management strategies in response.
	+ Conduct a comprehensive reassessment of skin integrity, including observation during reassessment periods, where changes to skin integrity are identified and on return from hospital.
	+ Review processes and practices relating to monitoring of nutrition and hydration requirements, including intake.
* Ensure policies and procedures in relation to assessment, care planning, behaviour, and incident management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies and procedures in relation to assessment, care planning, behaviour and incident management, including reporting, assessment and monitoring processes.

Standard 8 requirement (3)(c):

* Ensure management and staff have the skills and knowledge to identify incidents of alleged abuse.
* Ensure management and staff are aware of their responsibilities in relation to allegations of assault, including reporting timeframes.
* Ensure policies and procedures in relation to compulsory reporting and incident management are effectively communicated and understood by management and staff.
* Monitor staff compliance with the service’s policies and procedures in relation to compulsory reporting and incident management.