St Joseph's House

Performance Report

22 Norman Street
PORT PIRIE SA 5540
Phone number: 08 8632 1450

**Commission ID:** 6961

**Provider name:** The Catholic Diocese of Port Pirie Inc

**Assessment Contact - Site date:** 22 July 2020

**Date of Performance Report:** 1 September 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)(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 consumers, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 10 August 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)(d) 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)(d) in this Standard. These Requirements were found Non-compliant following an Assessment Contact – Site conducted 14 January 2020 to 15 January 2020.

The Assessment Team assessed Requirement 3(b) in relation to Standard 3. At the Assessment Contact conducted 14 January 2020 to 15 January 2020, the Decision Maker found blood glucose levels for two consumers were not being well managed and timely escalation of blood glucose levels found to be out of range were not actioned or reported. Whilst the service has made some improvements in response to the Non-compliance identified at the Assessment Contact, the Assessment Team found these actions have not been adequately monitored. The Assessment Team were not satisfied the service adequately demonstrated effective management of high impact or high prevalence risks, specifically in relation to management of diabetes, pain, choking risks, falls and behaviours. 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 the Assessment Contact conducted 14 January 2020 to 15 January 2020, in relation to Standard 3 Requirement (3)(d), the Decision Maker found staff were not escalating when a consumer had deterioration, or a change of a consumer’s health condition was recognised and responded to in a timely manner. The service 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 Assessment Team found the organisation did not adequately demonstrate effective management of high impact or high prevalence risks for consumers, specifically in relation to management of diabetes, pain, choking risks, falls and behaviours.

In relation to diabetes management:

The Assessment Team were not satisfied diabetes management for three consumers was effectively managed. This was evidenced by the following:

* Consumers’ blood glucose levels were not consistently undertaken as directed.
* Diabetes management plans were not consistently updated to reflect Medical officer directives recorded on the Diabetes action plan.
* Inconsistency in recording of blood glucose levels in the electronic system and medication charts.
* Inconsistency of information relating to management and reporting of blood glucose levels out of range noted on Diabetes management plans and Diabetes action plan.

The approved provider’s response indicated they accepted the Assessment Team’s findings. The approved provider’s response demonstrated the organisation has been proactive in addressing the issues relating to diabetes management identified in the Assessment Team’s report and have implemented a number of actions, including:

* Daily checks of blood glucose levels for insulin dependent diabetic consumers.
* Review all insulin dependent diabetic consumers’ information for congruency.
* Diabetes management plan template created.
* Developed a Diabetes management work instruction and Sick day management plan.
* Distributed Management of consumers with diabetes policy and Diabetes Management work instruction to clinical staff. Staff are required to read the documents and sign a declaration.

In relation to pain management:

The Assessment Team were not satisfied the service adequately demonstrated one consumer’s pain was effectively assessed, monitored, managed or reviewed. This was evidenced by the following:

* Documentation viewed indicated between 10 June and 22 July 2020 the consumer expressed pain on 14 occasions. On 13 occasions, staff did not record evaluation of effectiveness of treatments provided.
* Nursing staff could not explain why effectiveness of management strategies had not been completed following treatment.

The approved provider’s response indicated they accepted the Assessment Team’s findings. The approved provider’s response demonstrated the organisation has been proactive in addressing issues relating to pain management identified in the Assessment Team’s report and have implemented a number of actions, including:

* The consumer’s pain management plan has been reviewed.
* Education session for clinical staff relating to use of analgesia, PRN and pain management conducted by the Pharmacist on 14 August 2020.
* Toolbox education for clinical staff relating to Abbey pain scale conducted 31 August 2020.
* Medication management competencies are currently being completed by clinical staff.
* Distributed Pain management policy and work instruction to clinical staff. Staff are required to read the documents and sign a declaration.

In relation to management of consumers at risk of choking:

The Assessment Team were not satisfied the service adequately demonstrated one consumer who has been identified as at risk of choking and high aspiration is monitored and supported at meal times in line with care plan directives. This was evidenced by the following:

* The consumer’s care plan states ‘encourage to eat/drink slowly, take small amounts to prevent build up and rest between mouthfuls’.
* The Assessment Team observed the consumer seated at the dining room table eating about a dozen mouthfuls of minced food. A staff member was seated next to the consumer assisting another consumer. The staff member walked away leaving the consumer for approximately two minutes.
* The Assessment Team observed the consumer again eating their dessert with no staff in attendance.
* During observations, staff were not observed to provide encouragement or directives to the consumer in line with the consumer’s care plan.
* One care staff member said the consumer is able to eat by themselves as long as they are sitting upright. Additionally, they stated they do not need to check or encourage the consumer as “she is a good eater”.

The approved provider’s response indicated they accepted the Assessment Team’s findings. The approved provider’s response demonstrated the organisation has been proactive in addressing the issues relating to observations of a consumer at risk of choking identified in the Assessment Team’s report and have implemented a number of actions, including:

* The consumer has been reviewed by a Speech pathologist.
* A meeting with the consumer’s authorised representative, Medical officer, Speech pathologist and clinical staff to be arranged.
* Spot checks on mealtime experiences undertaken with issues identified actioned.
* Personal care attendants duties reviewed to include meal assistance and supervision of at risk consumers.
* Toolbox training session for Personal care attendants relating to Customer service, including dining room monitoring and correct positioning of consumers prior to mealtimes to be conducted.

In relation to falls management:

The Assessment Team were not satisfied the service adequately demonstrated that assessment and management of one consumer following a fall was in line with the service’s post fall policy. This was evidenced by the following:

* Documentation viewed indicates the consumer was transferred from the floor via a lifter and back onto the bed following a fall. The incident form indicates no obvious injuries or pain were initially noted. However, once on the bed, pain and mild weakness was evident in the left leg. The consumer’s leg was noted to be ‘shortened and rotated’.
* Clinical staff stated the organisation’s Post falls protocol directs staff not to move consumers where an injury is suspected, contact the ambulance service and transfer to hospital for further investigation.
* The consumer’s Fall’s risk assessment dated 5 May 2020 following the fall indicates the consumer is to wear hip protectors, however, this is not documented in the care plan.

The approved provider’s response indicated they accepted the Assessment Team’s findings. The approved provider’s response demonstrated the organisation has been proactive in addressing the issues relating to falls management identified in the Assessment Team’s report and have implemented a number of actions, including:

* The consumer’s care plan, including mobility has been updated.
* Falls protocol, including a flow chart has been distributed to clinical staff. Staff are required to read the documents and sign a declaration.
* Toolbox sessions and online learning modules completed by clinical staff relating to Documentation for incident reporting and Falls: Managing risks conducted in August 2020.

In relation to behaviour management:

The Assessment Team were not satisfied the service adequately demonstrated that one consumer’s incidents of physical aggression were consistently assessed, monitored or managed. This was evidenced by the following:

* A clinical staff member stated they had noted a culture of staff acceptance of consumers’ physical aggression, rather than identifying the behaviour as requiring assessment, evaluation and management strategies to keep others safe.
* Progress notes have reflected incidents of physical aggression with no corresponding incident report to escalate the behaviours and prompt further investigations.
* Progress notes for one consumer describe three incidents of physical aggression between 4 and 10 June 2020. There are no corresponding incident reports. The consumer was subsequently diagnosed with a urinary tract infection.
* A summary care plan dated 29 June 2020 does not include behaviours relating to physical aggression. Staff referring to the care plan would not be alerted to potential for physical aggression, impulsive nature of the behaviour, triggers or strategies required to safely provide care to the consumer. Clinical staff stated a behaviour evaluation, including management strategies for physical aggression had been completed.
* The organisation’s Behaviour management policy does not expand on triggers for behaviour, such as pain or infections and does not provide guidance in relation to behaviour assessment processes.

The approved provider’s response indicated they accepted the Assessment Team’s findings. The approved provider’s response demonstrated the organisation has been proactive in addressing the issues relating to behaviour management identified in the Assessment Team’s report and have implemented a number of actions, including:

* The consumer’s care plan has been updated.
* A pain and medication management review for the consumer has been undertaken by the Medical officer.
* The Behaviour management policy has been updated to include consideration of medical issues, such as pain and urinary tract infections.
* Toolbox sessions for clinical staff relating to documentation for incident reporting and Dementia: An introduction for care and clinical staff to be conducted.

I acknowledge the approved provider’s proactive response to the Assessment Team’s findings. However, I find that at the time of the Assessment Contact the service did not effectively manage high impact or high prevalence risks associated with the care of each consumer. This included high impact or high prevalence risks relating to management of consumers’ diabetes, pain, choking risks, falls and behaviours. The approved provider’s response acknowledges the organisation has some deficits and has demonstrated strategies and plans are in place to ensure timely rectification of issues identified in the Assessment Team’s report.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, Non-compliant in relation to Standard 3 Requirement (3)(b).

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

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

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

* Relevant policies have been developed and all clinical staff have attended training in relation to identification of a deterioration or change in a consumer’s condition and how to escalate concerns and ensure timely response.
* A Deterioration and Health Changes policy has been developed and supports staff to understand their role in managing consumers’ deterioration, including reporting changes, gathering information, undertaking clinical assessment, monitoring and referral.
* A Skin and Pressure Injury Management policy dated 30 March 2020 outlines staff responsibilities and includes best practice information on alterations in skin integrity, pressure injury stages, assessment and management.
* A Reporting of Changes in Consumers’ Needs procedure dated 1 February 2020 outlines reporting responsibilities of Personal care workers and Registered and Enrolled nurses.
* Work instructions and transfer facsimile templates have been developed and updated to prompt staff to provide Medical officers and hospital staff with critical clinical information about consumers.
* Clinical staff attended toolbox training sessions related to Recognition and action of deterioration and health changes in February and June 2020.
* Care staff have attended a toolbox training session relating to Reporting a consumer’s deterioration in February and June 2020.

In relation to Standard 3 Requirement (3)(d), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

Overall, consumers and representatives were confident staff would respond promptly if consumers’ health status changed or if they needed medical and/or other referrals.

Staff described changes in consumers’ mental health, cognitive or physical function which they would escalate/report to clinical staff. Clinical staff described observations and assessment processes they would initiate in response to a consumer’s deterioration. Additionally, they described information they would provide to Medical and/or hospital staff to ensure critical information was received.

The organisation has monitoring processes in relation to Standard 3 Requirement (3)(d) to ensure deterioration of a consumer’s heath or condition is recognised and responded to in a timely manner.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, Compliant in relation to Standard 3 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.

Standard 3 Requirement (3)(b):

* Ensure staff have the skills and knowledge to:
	+ Ensure appropriate charting and assessments are completed for all consumers, to identify high prevalent or high impact risks relating to the care of each consumer.
	+ Assess and implement appropriate pain management strategies for consumers and evaluate effectiveness of strategies implemented.
	+ Develop comprehensive care plans for consumers which include appropriate management strategies to assist staff to deliver care and services in line with consumers’ assessed needs.
	+ Escalate/report incidents, including in relation to challenging behaviours and behaviours which pose a risk to other consumers and staff.
* Ensure policies and procedures in relation to diabetes management, pain, choking risks, falls, behaviour, and incident management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies and procedures and consumers’ individual care directives in relation diabetes management, pain, choking risks, falls and behaviour management.
* Monitor staff compliance in relation to consumer care needs and preferences, ensuring management strategies are implemented in line with consumers’ care plans and assessed care needs.