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

**Site Audit date:** 28 April 2021 to 30 April 2021

**Date of Performance Report:** 28 June 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

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Non-compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Non-compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | 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 Site Audit; the Site Audit 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 Site Audit report received 24 May 2021.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Non-compliant as one of the six specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(c) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(c). I have provided reasons for my findings in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* staff seek to understand consumers as individuals and value their individuality. Consumers said staff seek to understand their interests, past lives, family history and what is important to them.
* staff always have time to talk and engage in small chit chat about consumers’ lives and this makes consumers feel valued.
* consumers can live their life according to their preferences and are supported to do so by staff.
* described receiving information regarding activities and other things consumers liked to do.
* they receive information in the form of emails and verbally from management and staff and feel they are kept well informed.

Policy and procedure documents provide direction and governance for staff in relation to dignity, respect, culture, diversity, choice, risk and privacy matters to support the provision of care and services. Documentation sampled by the Assessment Team, such as newsletters and meeting minutes included respectful language and a respectful approach towards consumers. Staff sampled consistently spoke about consumers in a manner that indicated respect and understanding. Additionally, staff demonstrated an understanding of each consumer’s past and present circumstances and how this impacted on the delivery of care.

Care staff were familiar with culturally safe practices and described how they change their approach to activities and care for consumers of differing cultural backgrounds. Care and lifestyle documents sampled included specific cultural needs and strategies to assist staff to ensure consumers’ cultural needs are met.

The service demonstrated how they support consumers to take risks to enable them to live their best life. Dignity of risk forms are completed where activities consumers choose to partake includes an element of risk; risks are discussed in consultation with consumers and/or representatives and mitigation strategies developed. Staff sampled provided examples of how they support consumers to take risks and were familiar with Dignity of risk forms.

The Assessment Team observed communication clearly displayed throughout the service on noticeboards and brochure stands. Information was noted to be current and in a format that was easy to understand and enabled consumers to exercise choice. Management described various methods of providing information to consumers, including through the organisation’s website, brochures, newsletters, meeting forums and care plan evaluation processes. Staff described strategies they use to provide information to consumers with cognitive impairments or communication difficulties.

Consumers and representatives sampled were satisfied the service respects consumers’ privacy and maintains confidentiality of personal information. Staff demonstrated an understanding of maintaining consumer confidentiality; this was confirmed through observations of staff practice made by the Assessment Team.

The Assessment Team found the organisation has monitoring processes to ensure a culture of inclusion and respect for consumers; supports for consumers to exercise choice and independence and consumers’ privacy is respected.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Non-compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

The Assessment Team were satisfied the service demonstrated how each consumer is supported to exercise choice and independence, including in relation to making decisions about who is involved in their care and communicate their decisions. However, the Assessment Team were not satisfied the service demonstrated effective processes to support consumers to maintain connections with others and maintain relationships of choice, including intimate relationships. This was evidenced by the following:

* Representatives indicated they were not able to visit their family members on Sundays without prior arrangement. The following feedback was provided to the Assessment Team by representatives.
* Sunday was their main visiting day and it meant certain family members did not visit anymore as it did not fit in with work and school commitments during the week.
* Their family were upset the service did not have unrestricted visiting on Sundays and the consumer is missing out on visits because of it.
* Staff said it’s a nuisance because of signing in and this made them feel unwelcome.
* They preferred to visit in the morning due to both the consumer’s preference and their preference. However, the only visiting hours option is in the afternoon between 1.00pm and 3.00pm.
* Management stated Sunday visiting had stopped, however, they were flexible in making arrangements for people who felt they needed to come in. Flexibility is provided to representatives who assist their family member with meals and for consumers who are palliating.
* Management said the arrangement was in place because “manning the door and the signing in process took a staff member off the floor and this was not viable”.
* Assessment and care planning documents did not consider two couples’ needs, goals and preferences in relation to maintaining and/or engaging in an intimate relationship while residing at the service.
* Care staff did not know if either couple required consideration regarding maintaining their relationship and intimacy and they had not thought about it.
* A clinical staff member said although the service doesn't have ‘formal supports’ to recognise married relationships, staff always knock and wait before entering any consumers’ room.
* All assessment and plans documented in the four files for both couples noted ‘give privacy when needed’.
* Clinical management said the service had not considered intimacy during assessment and care planning for couples.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions to resolve the deficiencies identified, as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Visiting hours have been reviewed and now include scheduled times on Sunday. Anticipate additional changes will be made following completion of the COVID-19 vaccination program.
* Information relating to the changed visiting hours has been provided to consumers and representatives.
* Requests for visits outside the scheduled hours is considered on a case-by-case basis.
* Updated care plans to reflect needs and goals regarding intimate relationships.
* Researched best practice regarding maintaining privacy and intimacy in relationships, resulting in development of a work instruction.
* Sexuality and intimacy forms part of the overall assessment and planning process. All couples have been reassessed using a specified assessment tool.
* Staff are receiving further training in privacy and dignity and maintenance of married couple relationships for consumers living in aged care.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service’s processes did not ensure consumers were supported to maintain relationships of choice, including consideration of married couples to maintain and/or engage in intimate relationships while residing at the service. Weekend visiting hours did not consistently allow consumers’ family members, who may not have been able to visit at any other time, to visit consumers. This had resulted in impacts for consumers, including missing out on visits from loved ones.

I also find that assessment and care planning processes did not consider the needs, goals and preferences of married couples in maintaining and/or engaging in intimate relationships. Strategies documented in consumer care files was limited to ‘give privacy when needed’ and staff sampled did not demonstrate an understanding of supporting consumers’ intimate relationships.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(c) in Standard 1 Consumer dignity and choice.

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(a) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-Compliant with Requirement (3)(a). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they feel like partners in the ongoing assessment and planning of their care and services. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* assessment and care planning is inclusive of those consumers who want to be involved in their care.
* feel included in care decisions and staff talk to consumers regarding care and services.
* are informed of changes and appointments and are involved in discussions regarding specialist appointments.
* have not seen their family member’s care plan, however, staff inform them of any changes.
* remember being shown the consumer’s care plan and confirmed their satisfaction with how staff communicate regarding care and services.

The service has processes to ensure consumers’ goals, needs and preferences, including advance care planning and end of life planning. Consumer files sampled demonstrated consultation with consumers and/or representatives occur on entry and ongoing. This includes end of life care. Where consumers do not wish to discuss end of life care planning or advance care planning, this is documented in the care files.

Care plan information is summarised from a suite of assessments, including risk assessments. Care planning information was individualised and included input from other health professionals. Clinical staff described processes for completing care plan reviews, and consumer files sampled demonstrated consumers and others are involved in assessment and planning processes. Care plans are available to consumers and representatives on request.

The service demonstrated care and services are regularly reviewed, including when circumstances change or when incidents occur. Clinical staff stated unresolved pain, mobility changes, falls and changes in swallowing ability or speech triggers review of consumers’ care. Clinical staff are alerted when care plan reviews are due through the electronic care system.

The Assessment Team found the organisation has monitoring processes to ensure initial and ongoing assessment and planning is conducted in partnership with consumers and has a focus on optimising health and well-being in accordance with consumers’ needs, goals and preferences.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team were not satisfied the service demonstrated that assessment and planning informs the delivery of safe and effective care and services. Deficiencies identified related to weight loss and nutritional requirements for two consumers. This was evidenced by the following:

* A consumer (Consumer A) recorded a weight loss of 7.1kg over a period of three months.
* An assessment document states ‘insidious weight loss over the last 2 years’. There is no rationale recorded as to why Consumer A continues to lose weight or directives for further investigation.
* A consumer (Consumer B) recorded a weight loss of 5.4kg over a three month period.
* Consumer weights are monitored through a monthly report. The report for the month preceding the Site Audit identified both Consumer A and B’s weight loss. However, actions, such as reassessment, care evaluation or consideration of impacts from other areas of care were not documented.
* Consumer A and B’s Nutrition and hydration assessments and care plans, risk screening tools and care evaluations were completed two months prior to the Site Audit. Information relating to recent weight loss or updated strategies to manage risks of ongoing weight loss were not included.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Both consumers’ care plans will be reviewed and staff informed of how to monitor weight loss.
* Full care evaluations have been completed for both consumers, including Nutrition and hydration assessments and Nutritional assessment tools.
* Clinical staff education/toolbox talks to include weight management, nutrition and hydration and a work instruction for the Resident of the day process.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, assessment and planning processes did not effectively inform the delivery of safe and effective care. For Consumers A and B, risks in relation the consumers’ health and well-being were not identified to inform delivery of safe and effective care. Recent weight loss was not considered through the care evaluation process and strategies to manage the risk of further weight loss were not considered. Additionally, actions, such as reassessment or consideration of impacts on other areas of care were not considered in response to the identified weight loss.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

### Requirement 2(3)(e) Compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# 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

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(b) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-Compliant with Requirement (3)(b). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they get personal care and clinical care that is safe and right for them. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* staff identify any problems that may be emerging and initiate referrals to the Medical officer.
* staff managed a consumer’s diabetes well; the representative was kept informed and a referral to the Medical officer occurred.
* consumer needs and preferences are effectively communicated between staff.
* staff are very good at informing representatives of any incidents or changes to a consumer’s condition.
* consumers have access to Medical officers and other relevant health professionals when they need it.
* staff ensure visitors to the service always follow infection control rules.

The service demonstrated how consumers are provided with safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Clinical staff described how consumers’ comfort is monitored through regular reviews of pain, repositioning, massage and hygiene care. Consumer files sampled included consumers’ end of life wishes. A care file for a consumer who had received end of life care demonstrated consultation with representatives and the Medical officer in relation to optimising the consumer’s comfort had occurred. Additionally, documentation demonstrated the consumer’s pain was monitored and managed.

Documentation viewed demonstrated where consumers were noted to have deteriorated or changes to their mental health or cognitive or physical function were identified, actions were initiated in a timely manner and referrals to Medical officers or allied health specialists were undertaken. Additionally, there are processes to ensure information about consumers’ condition, needs and preferences is documented and communicated within the organisation and with others where the responsibility for care is shared.

The service demonstrated appropriate infection control measures are in place. Procedure documents relating to infection control, practices to promote appropriate antibiotic prescribing and antimicrobial stewardship are available to guide staff practice. Staff sampled were familiar with procedure documents, as well as outbreak management processes. An Infection control lead has been appointed.

The Assessment Team found the organisation has monitoring processes to ensure delivery of safe and effective personal and clinical care, in accordance with consumers’ needs, goals and preferences to optimise health and well-being.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirements (3)(a), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

### 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 were not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer. Deficiencies related to management of weight, nutrition and hydration and falls for three consumers. This was evidenced by the following:

Consumer A

* The consumer recorded a weight loss of 7.1kg over a three month period.
* Clinical management stated the weight loss was attributed to a 19 day period where the representative requested a change to the consumer’s diet. The representative was informed the consumer had lost 2.6kg.
* Clinical management stated weights are evaluated each month through a Resident of the day process. Two of four Resident of the day processes for 2021 had not been completed for Consumer A.
* The Resident of the day for the month preceding the Site Audit recorded a weight loss of 3.9kg. No follow up actions were recorded.
* The Resident of the day for April 2021 reported ‘nil issues’.
* The most recent evaluation of weight, nutrition and hydration management occurred two months prior to the Site Audit.
* Risk screening tools completed two months prior to the Site Audit identified Consumer A as moderate nutritional risk and at risk of malnutrition.
* Clinical management stated no actions were taken in response to the assessment findings, such as referral to a Dietitian or monitoring of food and fluid intake.
* Clinical management stated no particular strategies are in place regarding the consumer’s weight loss and nutrition and hydration needs.
* The service’s Nutrition and hydration work instruction indicates the care plan should be reviewed if there is evidence of weight loss. Clinical management said this should have happened, including an evaluation of weight, and actions put in place when a loss of more than 2kg in one month is identified.
* Consumer A had five falls in a four month period. Only one fall was recorded in the incident management system.
* Of the four falls not recorded, three were recorded as ‘near misses’ in the progress notes. One incident was not recorded as either.
* The near miss incidents were not recorded in the General incident analysis report for a two month period. Clinical management were not aware of these incidents as they were not recorded through the incident management system.
* Risk mitigation management strategies were not included on the incident analysis report. Management stated general interventions are implemented. Management had not considered investigation of the cause or development of strategies in line with the findings.
* Neurological observations following unwitnessed falls were not consistently undertaken. Charting showed one set of neurological observations recorded for only one of the five falls.

Consumer B

* The consumer recorded a weight loss of 5.4kg over a three month period.
* A Care evaluation completed three months prior to the Site Audit indicates Consumer B has a history of weight loss.
* The representative was unaware of the consumer’s recent weight loss and stated prior to 2021, they had been informed the consumer had gained weight.
* Resident of the day documentation indicates representatives were not consulted in line with the service’s process and weight loss management was not recorded as having been discussed with family.
* Clinical management stated the consumer has not been reviewed by a Dietitian and monitoring of food and fluid intake has not been undertaken.

Consumer C

* A Care evaluation in March 2021 indicates Consumer C had 11 falls in the previous three months and five falls in April 2021.
* Neurological observations were recorded for six of 10 falls.
* Only one set of observations were recorded on five occasions with neurological observations recorded for a 24 hour period for one of the incidents.
* Clinical management stated neurological observations are required to be recorded for a 24 hour period. However, the service’s Falls management procedure flowchart does not include frequency or length of time the observations need to be recorded to guide staff.
* The Incident analysis for February and March 2021 does not include actions to mitigate risk of further falls.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Clinical staff will be required to complete toolbox talks relating to weight management, nutrition and hydration and falls, including classification and neurological observations.
* Consumer A’s care plan and evaluation has been reviewed and a Dietitian review has occurred.
* Consumer B’s care review and evaluation has been updated in consultation with the representatives. Dietitian reviews have occurred.
* Consumer C’s falls risk and risk assessment to be updated. Actions to mitigate risk of further falls will be included in incident analysis at the end of each month.
* Neurological observations work instruction to describe frequency and time frame for observations.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, high impact or high prevalence risks, specifically in relation to weight management and falls, were not effectively managed for each consumer. Weight loss for Consumers A and B had not been managed in line with the service’s process. For Consumer A, Resident of the day and risk assessment processes did not consider follow up actions in response to weight loss. For Consumers A and B, management stated additional actions, such as food and fluid monitoring or referrals to the Dietitian had not occurred.

I have also considered risks related to falls for Consumer A and C had not been effectively identified or managed. For Consumer A, falls had not been correctly classified in the service’s incident management system. As a result, management were not aware of the falls and investigation of the cause and review and/or development of further strategies did not occur.

For both Consumers A and C, neurological observations had not been consistently completed following falls. Clinical management stated these observations are to be recorded for a 24 hour period. However, the organisation’s falls management flowchart did not include sufficient detail relating to the frequency or length of time observations need to be completed to guide staff practice. Additionally, the General incident analysis report did not include risk mitigation management strategies for individual consumers, including for incidents sustained by Consumers A and C. I find this information is more aligned with the intent of Standard 8 Requirement (3)(d) and have considered it in my finding for that Requirement.

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

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### 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.*

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

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

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

### 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.*

# STANDARD 4 COMPLIANT Services and support 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 Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. The following examples were provided by consumers during interviews with the Assessment Team:

* feel supported by staff to do the things they want do to.
* have input into the menu and any concerns in relation to food are addressed and feedback provided.

Initial and ongoing assessment processes assist to identify what and who is important to consumers, background, life story and experiences, current interests, religious and other cultural practices and support required to help consumers do the things they want to do. Individualised care plans are developed from information gathered are reviewed on a regular basis to ensure they remain reflective of consumers’ current needs and preferences. For sampled consumers, staff could describe what was important to consumers and how they assist, and support consumers do things important to them.

The lifestyle program includes a range of activities and incorporates cultural and religious events. Consumers are encouraged to provide feedback on the activities program which is tailored to the consumer’s needs and preferences. Lifestyle staff provided examples of how they support consumers to do things of interest to them either one-to-one or in a group setting. External organisations provide support to the service and complement the activities program. Consumers sampled said they always have things to do as the service supports them to keep active and they enjoy it when volunteers come to the service, describing them as nice and supportive.

Care planning documents sampled included information about consumers’ emotional, spiritual and psychological well-being and support strategies. Additionally, consumer files demonstrated emotional support had been provided when consumers were feeling low or were missing their family. Staff sampled described how they supported consumers when they were upset and showed familiarity with consumers’ emotional, spiritual and psychological needs and preferences. Additionally, consumers stated staff are supportive of their emotional, spiritual and psychological well-being and regularly check on them.

Consumers sampled described how they are supported to have and maintain social and personal relationships, including through leaving the facility with family or friends. Consumers said during COVID-19 restrictions, the service supported them to converse with friends and family through a range of different avenues. Consumer files sampled demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared. Consumers stated they are referred to appropriate allied health services when needed, including pastoral support services. Consumer files demonstrated care and lifestyle consultations, including those with Medical staff, allied health and others is recorded in progress notes and care plans.

Most consumers and representatives were satisfied with the quality of the food and alternatives available. Consumers’ dietary needs and preferences are obtained on entry and ongoing with the information also provided to hospitality staff to facilitate provision of meals. Catering staff described individual preferences for consumers and demonstrated an understanding of consumers’ dietary needs. Documentation viewed demonstrated care plans are updated following allied health reviews.

The Assessment Team observed equipment provided to consumers to be comfortable, clean and well maintained. Cleaning, maintenance and audit processes ensure equipment is clean and well maintained. Consumers said there was enough equipment and staff clean equipment daily.

The Assessment Team found the service has monitoring processes to ensure safe and effective services and supports for daily living that optimise consumers’ independence, health, well-being and quality of life.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with all Requirements in Standard 4 Services and supports for daily living.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

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

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

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

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

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 NON-COMPLIANT 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 Quality Standard is assessed as Non-compliant as two of the three specific Requirements have been assessed as Non-compliant.

The Assessment Team have recommended Requirements (3)(b) and (3)(c) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-Non-compliant with Requirements (3)(b) and (3)(c). I have provided reasons for my finding in the specific Requirements below.

In relation to Requirement (3)(a) in this Standard, the Assessment Team found overall, consumers sampled considered that they feel they belong in the service and feel safe and comfortable in the service environment. Consumers stated the service environment is safe, welcoming and easy to navigate.

The Assessment Team observed the entrance to the service environment to be welcoming and a staff member was at reception to greet visitors and assist with sign in processes. Dining and activity areas were equipped with suitable furniture and there are smaller areas available for small groups to congregate. The service environment appeared welcoming, easy to navigate and had a home like feel and consumer rooms were decorated with personal belongings.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirement (3)(a) in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Non-compliant

*The service environment:*

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

The Assessment Team were not satisfied the service effectively demonstrated the outdoor environment is safe, clean, well maintained and comfortable. This was evidenced by the following:

* Three consumers said they like to sit in the outdoor areas each day. However, they are put off by the ‘dirtiness’ and do not always use the areas when they would like to.
* A small veranda area was dirty with cobwebs, including on mounted light fittings and bird droppings were observed on handrails. Soft furnishings on chairs appeared to have dirt and dust on them and dirt was layered on the outdoor table.
* An outdoor table in a courtyard area was dirty, cushions on two outdoor chairs were ripped and other wrought iron chairs did not have cushions.
* The Maintenance schedule documented a daily visual check of the courtyard areas which were noted to be signed off each day. A staff member stated this signified the areas had been assessed as clean and comfortable for use.
* An Environment and safety audit, which was not dated, did not identify the courtyard areas as needing cleaning.
* The Hazard report log recorded one incident for 2021. Management said they recognised staff needed more training in identification and reporting of hazards and this would occur in 2021.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Additional cleaning of balconies was actioned during the Site Audit.
* The service is working with Council and implementing actions to deter pigeons.
* Maintenance staff have been contracted to power hose courtyards weekly.
* Soft furnishings have been replaced and furniture cleaned.
* Courtyard audits have been added to the Maintenance schedule and will be checked weekly.
* Working to personalise Maintenance schedules.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, outdoor areas were not safe, clean or well maintained. Three consumers sampled indicated they like to sit in the outdoor areas each day and because of the ‘dirtiness’ they do not always use the areas when they would like to. Additionally, I have also considered that processes used to monitor the outdoor areas had not identified any issues with cleanliness or suitability of the outdoor furniture. A visual check of the courtyard areas on the Maintenance schedule had been signed off daily indicating the areas had been assessed as clean and comfortable for use.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

### Requirement 5(3)(c) Non-compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

The Assessment Team were not satisfied the service effectively demonstrated safe systems for all care equipment or scheduled maintenance. This was evidenced by the following:

* Hoist sling tags did not record safety check information. Management stated safety checks are not performed on any slings.
* Management were not aware of how long the slings had been in service and stated they had never been safety checked.
* Slings are not included in the in-house maintenance program to monitor condition.
* Maintenance has not been consistently completed in line with the (preventative) Maintenance schedule 2021. This included fixtures and equipment, including wheelchairs.
* Several maintenance items were noted to be signed on an ad hoc basis and not completed as scheduled.
* A task was marked with an arrow across the page. Staff were not able to identify if these items had been actioned.
* Staff were not able to say when the preventative maintenance had last been completed as documentation was not consistently completed.
* Comfort chairs were observed to be delaminated of vinyl in several areas compromising the wipeable surface area and posing a potential infection control risk.
* Care and nursing staff said the four available comfort chairs in use all have delamination and are not able to be wiped down without the underside material becoming damp.
* Care staff said clinical management were aware the chairs had been delaminating for some time, however, they have not been repaired.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Completed a sling register and slings will be inspected three monthly by the Physiotherapist.
* Introduced a work instruction to include regular checks and laundering of slings.
* Contracted a contractor to undertake safety checks of all slings in June 2021.
* Wheelchairs are being serviced by a contractor. Old equipment has been removed from the service.
* All equipment identified at the Site Audit has been actioned.
* The in-house preventative Maintenance schedule has been reviewed and updated and is to be presented to management weekly for signing.
* Comfort chairs have been replaced by two new chairs and two are being recovered. The remaining chairs will all be re-covered over a set schedule.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service’s maintenance and monitoring processes did not effectively ensure furniture, fittings and equipment were safe, clean and well maintained. Maintenance records had not been consistently completed and/or maintained and, as a result, staff were unsure when preventative maintenance had last been completed. Safety checks for hoist slings were not included on the Maintenance schedule to ensure the safety and integrity of the slings was maintained and monitored and risks to consumers when using the slings minimised. I have also considered that equipment in use, specifically comfort chairs, were not well maintained. Chairs were observed to be delaminated of vinyl in several areas compromising the integrity of the material, posing a potential infection control risk.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(c) in Standard 5 Organisation’s service environment.

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as one of the four specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(d) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-Non-compliant with Requirement (3)(d). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* feel comfortable providing feedback, including verbally, through surveys, meetings and feedback forms and management has been responsive to feedback.
* management are very approachable and are always walking around the building.
* have either not needed to make complaints or they have been minimal in nature in which staff responded to at the time.
* described providing feedback regarding food and how concerns were resolved.
* staff work with them to ensure feedback and complaints are actioned and improvements made. Consumers provided examples of the service taking action, primarily in relation to food, and stated they were satisfied with the outcome.

Consumers and representatives are provided with information in relation to internal and external feedback and complaints avenues, language and advocacy services on entry. Reminders relating to feedback processes are also included in the monthly newsletter. Feedback forms and information in relation to internal and external feedback mechanisms and advocacy was also noted to be displayed throughout the service.

Staff described how they respond to issues or concerns on behalf of consumers and described strategies they use to assist consumers with limited English or cognitive impairments to provide feedback. Clinical staff described how minor complaints raised, including in relation to food or care needs, are responded to promptly. While staff sampled were unfamiliar with the term open disclosure, they could describe the process of acknowledging, responding and apologising when mistakes are made. Clinical staff sampled were familiar with open disclosure processes.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirements (3)(a), (3)(b) and (3)(c) in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team were not satisfied the service effectively demonstrated feedback and complaints are reviewed and monitored regularly to ensure complaints are actioned and trends identified. This was evidenced by the following:

* Only one complaint was recorded in the Complaints register for a four month period.
* Comments, complaints and feedback from consumers, representatives and staff documented in a menu survey, staff and consumer meeting minutes and email correspondence had not been recorded in the Complaints register.
* Hospitality staff said they receive complaints and suggestions about food on a regular basis which is recorded and discussed at resident meetings. Staff said they assume this is then entered into the Complaints register but were unsure.
* Management stated:
* Not all feedback and complaints are recorded as they are addressed by staff at the time. Staff may not necessarily pass information relating to complaints to management.
* Acknowledged complaints recorded in meeting minutes and surveys should have been recorded in the Complaints register. This has likely impacted the ability to analyse any trends.
* Acknowledged the difference between suggestions and complaints and said suggestions are also not recorded.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* A new register for feedback and complaints to be implemented, along with a work instruction which will include how to trend complaints information.
* Complaints from meeting minutes to be transferred to the Complaints register monthly.
* Re-educate staff regarding reporting and recording complaints.
* Feedback and complaints toolbox for all staff set for November 2021.
* Feedback recorded in the survey and meeting minutes will be added to the Feedback and compliments register commencing May 2021.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, feedback and complaints, including feedback received through meeting forums and surveys were not consistently recorded. Management acknowledged that not all feedback and complaints are recorded as they are addressed by staff at the time. In coming to my finding, I have considered that information documented on the Complaints register is not reflective of the actual feedback and complaints being received by the service. This has resulted in complaints trends not being identified and, therefore, information received from complaints is not able to be effectively used to improve the quality of care and services.

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# STANDARD 7 COMPLIANT 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 Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

The Assessment Team found overall, most consumers were satisfied they get quality care and services when they need them from people who are knowledgeable, capable and caring. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* there are enough staff, and they even have time to chat.
* when consumers ring the call bell, it is answered quickly and they never have to wait long.
* staff are kind, caring, treat consumers with respect, are responsive to their needs and understand their preferences and interests.
* staff always go above and beyond in the level of care they give.
* staff are competent, knowledgeable and know what they are doing.

There are processes to ensure the workforce is planned to enable, and the number and mix of staff deployed enables, the delivery of quality care and services. The roster is adjusted based on consumer needs, staff and consumer feedback and incident data. There are processes to manage planned and unplanned leave. Staff sampled indicated they have enough time to complete their work and staffing shortfalls are managed. Staff were observed to be assisting consumers with care and dignity and did not appear to be rushed.

The Assessment Team observed staff interactions with consumers to be kind, caring and respectful of each consumer’s identity, culture and diversity. The compliments register showed numerous compliments from consumers and representatives in relation to the quality of care provided by staff.

The service demonstrated processes relating to staff recruitment, onboarding and ongoing training programs. Duty statements and work instructions are available to guide staff practice and outline specific roles and responsibilities. A training planner is in place which includes mandatory and non-mandatory training components. The training program is influenced by a range of inputs, including staff feedback, and there are processes to monitor staff completion of mandatory components. Staff sampled stated they felt the training program supports them in their roles.

A staff performance appraisal and development process is in place, including probationary and annual reviews. Staff performance reviews are conducted annually or as required. Assessment of performance is based on input from other staff, incident data, observations and training attendance. Additionally, consumer input in relation to staff competency and whether or not they are kind and caring is sought and considered during the performance assessment process.

The Assessment Team found the organisation has monitoring processes in place to ensure the workforce is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with all Requirements in Standard 7 Human resources.

## 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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### 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.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANT 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 Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(d) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(d). I have provided reasons for my findings in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled were satisfied the organisation is well run and that they can partner in improving the delivery of care and services.

Management described how consumers are supported to have input about their experiences and the quality of care and services. Documentation viewed demonstrated consumers are engaged through meeting forums, surveys, care plan review processes and feedback processes. Senior management attend consumer meeting forums to provide consumers an opportunity to speak to and provide feedback to management. A Resident liaison role has been established as a point of contact for consumers to discuss any issues or complaints they may have.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Senior management complete monthly reporting relating to various governance and clinical information from a service level. The monthly reports are provided to the Board and discussed at Board meetings. Consumer feedback and complaints are also presented to the Board.

The organisation demonstrated organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and reported, including to the Board. However, a consumer and their representative were not satisfied with financial costs they had incurred in relation to maintenance services for building and equipment which did not appear in line with legislative requirements.

The organisation has policies and procedures to guide staff practice in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Staff interviewed demonstrated an awareness of these policies and described how they implement these within the scope of their roles.

The Assessment Team found the organisation has monitoring processes to ensure the organisation’s governing body is accountable for the delivery of safe and quality care and services.

Based on the evidence documented above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### 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.*

### Requirement 8(3)(d) Non-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 were satisfied the service demonstrated effective risk management systems and processes relating to identifying and responding to abuse and neglect; supporting consumers to live the best life they can and managing and preventing incidents under the Serious Incident Response Scheme framework. However, the Assessment Team were not satisfied the service demonstrated effective incident management systems relating to high impact or high prevalence risks. This was evidenced by the following:

* A consumer had five falls in a four month period, however, only one fall was recorded in the incident management system.
* Of the four other falls, three were recorded as near misses and one was not recorded at all.
* Feedback from management indicated:
* they were unaware of the incidents, indicating they should have been reported as falls to ensure assessment and monitoring occurred.
* it is likely staff were unclear about how to classify falls and near misses and some staff may not have wanted to fill out an incident form.
* acknowledge reporting for the four month period was inaccurate due to the incorrect classification of the falls.

I have also considered information in the Assessment Team’s report under Standard 3 Requirement (3)(b) in my finding for this Requirement. Specifically, information relating to the organisation’s monitoring processes, including:

* Three near miss incidents recorded for one consumer were not recorded in the Incident analysis report for a two month period.
* Risk mitigation management strategies for individual consumers were not included on the General incident analysis report. Management stated general interventions are implemented and had not considered investigation of the cause or development of strategies in line with the findings.
* The service’s Falls management procedure flowchart does not include frequency or length of time neurological observations need to be recorded to guide staff.

The provider’s response indicates they accept the Assessment Team’s recommendation of not met. The provider’s response included investigations and actions implemented/to be implemented to resolve the deficiencies identified as well as documentation to support and/or demonstrate the actions initiated. Actions include, but are not limited to:

* Developed and implemented a centralised complaints register which includes monitoring risks relating to falls.
* Will provide guidance to staff relating to reporting and documentation of clinical incidents.
* Work instruction and toolbox session relating to falls and classifications.

Information included as part of the provider’s response for Standard 3 Requirement (3)(b) has also been considered, including:

* Clinical staff will be required to complete toolbox talks relating to falls, including classification and neurological observations.
* Actions to mitigate risk of further falls will be included in the incident analysis at the end of each month.
* Neurological observations work instruction to describe frequency and time frame for observations.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation’s risk management processes in relation to management of high impact or high prevalence risks were not effective. Incidents relating to falls for one consumer were not correctly classified or consistently recorded in the organisation’s incident management system. This has resulted in inaccurate falls data being recorded, effecting the organisation’s ability to identify trends and implement appropriate risk mitigation strategies.

I have also considered that policy and procedure documents, specifically for management of falls, do not provide sufficient information to guide staff practice. The Falls management procedure flowchart does not include frequency or length of time neurological observations need to be recorded. This has resulted in neurological observations not being consistently completed for consumers following falls incidents as highlighted in Standard 3 Requirement (3)(b).

For the reasons detailed above, I find The Catholic Diocese of Port Pirie Inc, in relation to St Joseph’s House, to be Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### Requirement 8(3)(e) Compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

# 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 1 Requirement 3(c)**

* Ensure consumers are:
* supported to maintain connections and maintain relationships, including intimate relationships.
* Ensure assessment and care planning processes consider the needs, goals and preferences of consumers maintaining relationships, including intimate relationships.
* Review processes, policies and procedures relating to supporting consumers maintain connections and maintain relationships.

**Standard 2 Requirement 3(a)**

* Ensure staff have the skills and knowledge to:
* initiate additional monitoring processes, complete assessments, review and/or develop management strategies and initiate referrals as appropriate in response to consumer weight loss.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to weight loss.

**Standard 3 Requirement (3)(b)**

* Ensure staff have the skills and knowledge to:
* recognise changes to consumers’ health and well-being, including weight loss, implement appropriate management strategies and initiate referrals to Medical officers and/or allied health specialists.
* Appropriately report, document and manage clinical incidents, such as falls.
* Initiate assessments, develop appropriate management strategies and monitor effectiveness of strategies relating to falls to minimise risk of injury.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks 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.

**Standard 5 Requirements 3(b) and (3)(c)**

* Review monitoring processes in relation to maintaining outdoor areas, including furniture.
* Review maintenance processes to ensure furniture, fittings and equipment are regularly inspected and maintained in line with the Maintenance schedule.
* Review monitoring processes to ensure issues relating to the service environment, furniture, fittings and equipment are identified and actioned.

**Standard 6 Requirement (3)(d)**

* Ensure feedback and complaints, including those received verbally and through meeting forums and surveys are documented on the Complaints register.
* Ensure feedback and complaints data is regularly reviewed to identify trends and improvement opportunities to the quality of care and services.

**Standard 8 Requirement (3)(d)**

* Ensure policies, procedures and guidelines in relation to incident management and reporting, falls and neurological observations provide sufficient information to guide staff.
* Ensure policies, procedures and guidelines in relation to falls, incident management and reporting and neurological observations are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management falls management and neurological observations.
* Ensure clinical incident data analysis identifies trends and includes consideration of risk mitigation strategies for consumers.