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 February 2022

**Date of Performance Report:** 8 April 2022

# Performance report prepared by

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# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(c) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(d) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received on 18 March 2022
* the performance report dated 28 June 2021 for the Site Audit conducted on 28 April 2021 to 30 April 2021.

# STANDARD 1 NON-COMPLIANTConsumer 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 Requirement has been assessed as non-compliant. The Assessment Team assessed Requirement (3)(c) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

Requirement (3)(c) was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, where it was found consumers were not effectively supported to maintain connections with others and maintain relationships of choice, including intimate relationships. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service did not meet Requirement (3)(c) in this Standard. The Assessment Team was not satisfied the service demonstrated each consumer is supported to exercise choice, including to make connections with others, as they were not always able to have visitors at a time of their choosing and have had no say in policies relating to visiting hours.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and I find the service non‑compliant with Requirement (3)(c). I have provided reasons for my findings under the specific Requirement below.

## Assessment of Standard 1 Requirements

### 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.*

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate effective processes to support consumers to maintain connections with others and maintain relationships of choice, including intimate relationships. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Care plan reviews to include the needs and goals of married consumers in intimate relationships.
* Implementation of processes to ensure initial and ongoing assessments include sexuality and intimacy.
* Education and training provided to lifestyle staff in relation to ‘sexuality and the older person.’
* Increasing visiting hours to 11:00am to 3:00pm daily, accommodating non‑scheduled visits with 24-hours’ notice and unrestrictive visiting times for palliative care consumers.

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

* Consumers and representatives were dissatisfied with the service’s policies in relation to visiting hours:
	+ One consumer said their family, who live a significant distance away, was in Port Pirie for one night and they were not able to see them as they arrived after visiting hours had ceased. The consumer reported they felt sad and isolated at times.
	+ One consumer said their family cannot attend site during scheduled visiting hours, as they work throughout the day and have commitments on the weekend.
	+ Two consumers said they would like to see their family more often but have no say in visiting hours.
	+ Three representatives reported visiting hours are too restrictive and are not long enough.
* Management reported visitors are usually not permitted to stay on site later than 3:00pm or be allowed entry if they attended site without an appointment, however, an exemption can be provided to visitors if they give a minimum of 24-hours’ notice.

The provider did not disagree with the Assessment Team’s findings and the provider’s response includes evidence of actions taken in response to deficiencies identified, which include, but are not limited to:

* Information in relation to visiting hours has been provided to consumers and representatives via multiple channels.
* Authorisation for unrestricted visiting hours has been provided to family members who assist consumers with meals and provision of care.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, each consumer was not supported to exercise choice, including to make connections with others.

I have considered that the service’s policies in relation to visiting hours did not support consumers to make decisions about when and how they maintain connections with others nor did they foster social inclusion, as they were inflexible and resulted in consumers not being able to see family at times or as often as they would like. Consumers and representatives provided examples of how the service’s restrictive visiting hours impacts consumers’ health and well-being, including feeling sad and isolated.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 1 Consumer dignity and choice.

# STANDARD 2 NON-COMPLIANTOngoing 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 Requirement has been assessed as non-compliant. The Assessment Team assessed Requirement (3)(a) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

Requirement (3)(a) was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, where it was found assessment and planning did not consider risks, specifically in relation to weight loss and nutrition, to inform the delivery of safe and effective care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service did not meet Requirement (3)(a) in this Standard. The Assessment Team was not satisfied the service demonstrated assessment and planning, including consideration of risks associated with wounds, pressure injuries, falls and chemical restraint, informs the delivery of safe and effective care and services.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and I find the service non‑compliant with Requirement (3)(a). I have provided reasons for my findings under the specific Requirement below.

## 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.*

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate assessment and planning included consideration of risks, specifically in relation to weight loss and nutrition, to inform the delivery of safe and effective care and services. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Implementation and distribution of work instructions in relation to managing unplanned weight loss.
* Providing staff education in relation to nutrition, hydration and ageing, unplanned weight loss, duty of care, negligence and bariatric care.
* Nutrition and hydration assessments are completed as part of assessment and planning processes.

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

Wounds and pressure injuries

Consumer A

* Following identification of a stage two pressure injury, the consumer’s skin assessment was reviewed.
* The skin assessment did not consider the current pressure injury and did not prompt implementation of strategies to manage the wound.
* Three staff provided different responses in relation to the consumer’s repositioning needs.
* Risks to wound healing, such as nutritional status, were not identified to inform the delivery of safe and effective care and services.

Consumer B

* A skin reassessment or pain assessment was not undertaken following identification of a wound on the consumer’s right hand.
* Management reported the consumer’s rubbing of the area and removal of the dressing was identified as a behaviour, rather than being caused by discomfort.
* While the cause of the wound was thought to be an insect bite, the cause of the bite was not assessed even after further similar lesions were identified.

Falls

Consumer C

* Documentation showed the consumer experienced frequent falls, including five falls within the month prior to the Assessment Contact, however, falls strategies had not been reassessed since November 2021.

Chemical restraint

Consumer D

* The consumer had been prescribed regular psychotropic medication for the purposes of managing behaviour.
* A behaviour assessment was undertaken in January 2022 and identifies wandering, verbal and physical behaviours displayed by the consumer.
	+ Successful interventions listed in the assessment are not specific or personalised and unsuccessful strategies were not included, as required under the *Quality of Care Principles 2014*.
	+ Behaviour influences in the assessment refer to ‘getting upset during conversations with other consumers or staff’, however, does not detail what aspects of the conversation causes upset. For example, topic of conversation, body language, volume of speaking.

Consumer E

* The consumer’s behaviour assessment was last updated in January 2022 and identifies that they become vocal and upset when unable to void or open their bowels.
	+ The behaviour assessment did not include personalised strategies to guide staff in preventing the trigger nor managing associated behaviours.
* Documentation showed the consumer was administered psychotropic medication on one occasion due to ‘restlessness on settling.’
	+ Non-pharmacological strategies trialled had not been documented, and the consumer’s behaviour assessment did not identify successful and unsuccessful strategies for management of their agitation, as required under the *Quality of Care Principles 2014*.

The provider did not disagree with the Assessment Team’s findings and the provider’s response includes evidence of actions taken in response to deficiencies identified, which include, but are not limited to:

* Care plan reviews have been undertaken for Consumers A, B, D and E.
* Skin and wound assessments for Consumers A and B have been updated to include photographs and measurements.
* In relation to Consumers D and E, referrals have been made to Dementia Support Australia and descriptive wall charts have been made to guide staff in behaviour management strategies.
* Staff have been documenting strategies used to reduce Consumer D’s anxiety.
* Staff training has been provided in relation to wound documentation and pressure area care.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, assessment and planning did not include consideration of risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

In relation to both Consumers A and B, I find that skin assessments were not reflective of current wounds to enable the implementation of appropriate management strategies and ensure staff have adequate information to guide the delivery of safe and effective care and services.

I have considered that Consumer C’s falls management strategies had not been reassessed to measure the effectiveness of those currently in place and implement new strategies, despite the consumer experiencing regular falls.

I have also considered, in relation to Consumers D and E, that identified behaviours, triggers and strategies were not sufficiently detailed and personalised, as required under the *Quality of Care Principles 2014*. This has not ensured staff have the required knowledge to guide delivery of care and services, in line with the consumers’ needs and preferences.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 3 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 Assessment Team assessed Requirement (3)(b) in Standard 3 Personal care and clinical care. All other Requirements in this Standard were not assessed; therefore, an overall rating of the Standard is not provided.

Requirement (3)(b) was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to weight loss, nutrition, hydration and falls. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service does not meet Requirement (3)(b) in Standard 3, as the service was unable to demonstrate effective management of high impact or high prevalence risks.

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 compliant with Requirement (3)(b). I have provided reasons for my findings under the specific Requirement below.

### Assessment of Standard 3 Requirements

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

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

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to weight loss, nutrition, hydration and falls. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Revision of the Resident of the day process to include analysis of health care issues, including weight, falls, medical officer visits, medication changes, infections and skin integrity.
* Implementing work instructions for neurological observations, reporting and documenting clinical incidents and managing unplanned weight loss.
* Staff education in relation to risk management, incident reporting, bariatric care, unplanned weight loss, nutrition, hydration and aging, duty of care and negligence, mental process for workplace risks and falls and neurological observations.
* Ongoing mentoring and onsite training for clinical staff.

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

Wounds

Consumer A

* Following identification of a stage two pressure injury on their coccyx, a wound care chart was commenced, measurements and photographs were recorded, and strategies were implemented to manage and clean the wound.
* Documentation showed the wound was not consistently photographed and measured in line with the organisation’s procedures.
* Progress notes demonstrate the wound was granulating and less red, however, the Assessment Team could not identify whether there was a decrease in size or healing.
* The consumer’s skin integrity assessment and care plan were inconsistent as they require staff to reposition the consumer every two hours and four times daily respectively.
	+ Charting documentation for a two-week sampled period indicated the consumer was not ever encouraged to reposition when lying on their back or sitting in a chair, therefore not relieving pressure from their coccyx.
	+ Three staff provided different responses in relation to the consumer’s repositioning needs.

Consumer B

* Following identification of a central lesion, a wound chart was commenced, and photograph taken, however, measurements were not included in the wound record. There was no evidence indicating pain charting had commenced.
* Photographs taken over a 14-day period indicate a significant increase in the affected area, however, measurements were not recorded in wound charting.
* The consumer reported they had requested to see a doctor, but it had taken three weeks for staff to make the arrangements. The consumer said by then, the wound had deteriorated from a tiny spot to an open, infected and painful wound that required a surgical biopsy. The consumer said they were concerned as they now had further spots similar in appearance to how the first one started.
	+ Documentation demonstrated the wound was identified on 21 January 2022 and reviewed by a medical officer on 26 January 2022, who prescribed antibiotic cream.
	+ Documentation showed on 31 January 2022, a fax was sent to the medical officer advising there had been no improvement. While management reported there had been no response to this request, a punch biopsy was noted as being ordered approximately 31 January 2022, indicating the medical officer had considered the status of the wound.
	+ Documentation showed on 7 February 2022, a further fax was sent to the medical officer which included photographs of the existing and new wounds. The fax requests confirmation that antibiotics are to be continued and reflects the consumer’s concerns. Management reported the medical officer did not respond to this fax.
	+ Documentation showed on 8 February 2022, another fax was sent to the medical officer advising of further wounds and requesting a review.
	+ Progress notes show a punch biopsy was undertaken on 15 February 2022 and the consumer was awaiting results at the time of the Assessment Contact.

Falls

Consumer C

* Care planning documentation for one consumer showed they were identified as a high risk of falls and as they continued to ambulate independently, a dignity of risk assessment was undertaken, and minimisation strategies were implemented.
* The Resident of the day review undertaken during February 2022 noted four falls in the previous month, which did not require hospital transfer.
* The organisation’s policy requires staff to undertake neurological observations at specific intervals following an unwitnessed fall or where there has been a head strike.
	+ Following two falls, neurological observations were not undertaken in line with intervals stated in the organisation’s policy. On one of two occasions, the consumer recorded abnormal results.
	+ While a rationale for the abnormal score was not provided, staff reported the consumer is often uncooperative with neurological observations. Management acknowledged this should have been clarified in charting.
* The consumer’s last mobility and falls assessment was undertaken three months prior to the Assessment Contact, despite being high risk with ongoing falls and potential progression with Parkinson’s disease.

Chemical restraint and Behaviour support plans

* Documentation demonstrated Behaviour evaluations (as a Behaviour support plan) were in place for two consumers subject to chemical restraint. However, they did not provide sufficient detail to guide staff in relation to identified behaviours, alternate strategies used, triggers and management strategies.
* For one consumer, there was no evidence indicating consent was informed.
* There was no evidence indicating chemical restraint was used as a last resort for management of agitation or behaviours.

The Assessment Team provided the following evidence demonstrating how the service understands and applies this Requirement:

* Following identification of significant unplanned weight loss for one consumer, a dietitian review was undertaken, and the consumer has since regained weight.
* Consumers’ high impact or high prevalence risks are recorded on a register and monitored via weekly meetings and handover processes. This register includes an assessment of risk to support consumer’s choices and details harm minimisation strategies.
* Handover sheets were observed to be used by staff with information about falls risks, including management strategies implemented.

The provider did not disagree with the Assessment Team’s findings and the provider’s response includes evidence of actions taken in response to deficiencies identified, which include, but are not limited to:

* Care planning documentation for all consumers named in the Assessment Team’s report has been reviewed and updated to ensure information is sufficient to guide staff in providing safe and effective care.
* A formalised process has been implemented to guide staff in communicating with medical officers and escalating incidents in a timely manner.
* The Dignity of risk form has been updated for the consumer experiencing frequent falls.
* Care plans for all consumers with wounds have been updated to include skin and wound assessments, measurements and photographs.
* Staff have received training in relation to updating care plans and wound documentation.

I acknowledge the provider’s response an associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates the service is compliant with this Requirement.

In relation to wound management, while evidence indicates areas for improvement in relation to wound documentation and monitoring, there was no evidence the wounds were not being managed. I find this evidence is more aligned with Requirement (3)(a) in this Standard, which was not assessed at the Assessment Contact.

In relation to Consumer A, while there was evidence indicating the consumer was not being repositioned in a manner that relieved pressure from their coccyx, assessment and planning documentation included conflicting information to guide staff in providing care in line with the consumer’s needs. I have considered the evidence presented by the Assessment Team in my findings for Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, which reflects the core deficiency.

In relation to Consumer B, while the consumer reported the medical officer did not review their wound in a timely manner, this was not supported by documentary evidence. Documentation showed the service was proactive in informing the medical officer when the wound had not improved and when further lesions continued to appear. The Assessment Team noted that pain charting had not occurred, despite the consumer reporting the wound was painful. However, the Assessment Team’s report did not include evidence demonstrating whether pain management strategies were in place and the effectiveness of them.

In relation to Consumer C, while evidence indicates areas for improvement in relation to post falls monitoring, there was no evidence indicating there was an adverse outcome for the consumer or that the consumer’s falls risk was not being managed. I find this evidence is more aligned with Requirement (3)(a) in this Standard, which was not assessed at the Assessment Contact. In relation to assessment and planning documents not being updated following ongoing falls, I have considered this evidence in my findings for Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, which reflects the core deficiency.

In relation to chemical restraint, information in the Assessment Team’s report does not indicate ineffective management of the consumer’s behaviours. While the Assessment Team’s report includes evidence that Behaviour evaluations include insufficient detail to guide staff practice, this has been considered in my findings for Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, which reflects the core deficiency.

Information included in the Assessment Team’s report also indicates a lack of evidence to demonstrate informed consent was obtained for the administration of chemical restraint and that it was used as a last resort. I find these deficiencies are more aligned with Requirement (3)(a) in this Standard and Requirement (3)(e) in Standard 8 Organisational governance, which were not assessed at the Assessment Contact.

Based on the information summarised above, I find the service compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

# STANDARD 5 NON-COMPLIANTOrganisation’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 one Requirement has been assessed as non-compliant. The Assessment Team assessed Requirements (3)(b) and (3)(c) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

Requirements (3)(b) and (3)(c) were found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, where it was found the service did not demonstrate:

* the service environment was safe, clean, well maintained and comfortable, and enabled consumers to move freely, both indoors and outdoors; and
* furniture, fittings, and equipment were safe, clean, well maintained and suitable for the consumer.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team recommended the service does not meet Requirement (3)(b) and meets Requirement (3)(c) in this Standard. While the Assessment Team was satisfied furniture, fittings, and equipment are safe, clean, well maintained and suitable for the consumer, evidence demonstrated the service environment was not clean and well maintained.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and I find the service non‑compliant with Requirement (3)(b) and compliant with Requirement (3)(c). I have provided reasons for my findings under the specific Requirements below.

## Assessment of Standard 5 Requirements

### 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.*

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate the service environment was clean and well maintained. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Engagement of a contractor for the service’s essential safety provisions.
* Furnishings have been purchased to replace those that were damaged.
* Weekly courtyard audits and pressure sprays have been added to the maintenance schedule.
* Six monthly workplace inspections are undertaken, and issues identified are discussed at the service’s continuous quality improvement and work health safety committee meetings.
* Training has been provided to staff in relation to hazard identification and risk management.

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

* Four consumers and representatives said they know the building is old and maintenance staff do what they can to ensure the structure is maintained. Two representatives said some walls are scuffed with marks.
* The schedule for room maintenance demonstrated 20 consumer rooms require repair work, as they are scuffed with black marks, skirting boards are damaged and some floor vinyls in bathrooms are lifting. The schedule does not include a timeframe for completion.
* Some communal areas were observed not to be well maintained. Skirting boards in corridors areas were swelling up, carpeted areas had water stains, walls had black scuff marks, some wall light covers were missing, and one shade sail was ripped and mouldy.
* Staff reported some consumers’ bathrooms are leaking water and the vinyl needs to be resealed and while there is a maintenance schedule for consumer room repairs, there is none for common area preventative maintenance.

The provider did not agree with the Assessment Team’s findings and asserts most of the deficits identified are superficial and do not pose risk to consumer safety.

I acknowledge the provider’s response an associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Assessment Contact, the service environment was not clean and well maintained.

I have considered that while the service implemented measures in response to deficits identified at the Site Audit conducted on 28 April 2021 to 30 April 2021, these measures were not effective, as maintenance issues observed by the Assessment Team were not self-identified and addressed. Whilst each issue individually may seem superficial, collectively they demonstrate failures in the service’s preventative and reactive maintenance processes.

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

### Requirement 5(3)(c) Compliant

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

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate safe systems for all care equipment or scheduled maintenance. Specifically, hoist sling tags did not record safety check information, slings were not included in the in-house maintenance program to monitor condition and maintenance was not consistently completed in line with the preventative maintenance schedule. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Engagement of a contractor for the service’s essential safety provisions.
* An internal audit of equipment has been completed, which resulted in the purchase of new, and repairs and servicing to existing equipment.
* Work instructions have been implemented in relation to sling, wheelchair and princess chair management.
* Six monthly workplace inspections are undertaken, and issues identified are discussed at the service’s continuous quality improvement and work health safety committee meetings.
* Training has been provided to staff in relation to hazard identification and risk management.

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

* Consumers confirmed they feel safe when staff use equipment, such as lifters, shower chairs or wheelchairs to assist them with activities of daily living.
* Staff described how they ensure equipment is clean and demonstrated knowledge of preventative and reactive maintenance, including through engagement of external service providers.
* Furniture and equipment were observed to be neatly stored, safe, clean and well maintained.
* The preventative maintenance schedule included hoist sling calibrations.
* Portable electrical equipment was tested and tagged.

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

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

# STANDARD 6 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 Assessment Team assessed Requirement (3)(d) in Standard 6 Feedback and complaints. All other Requirements in this Standard were not assessed; therefore, an overall rating of the Standard is not provided.

Requirement (3)(d) was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate feedback and complaints were reviewed and used to improve the quality of care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service meets Requirement (3)(d) in Standard 6, as the service was able to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

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 compliant with Requirement (3)(d). I have provided reasons for my findings under the specific Requirement below.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(d) Compliant

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

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate feedback and complaints were reviewed and used to improve the quality of care and services. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* A Feedback register has been created and implemented to include Consumer experience surveys, feedback, suggestions and complaints.
* Data captured in the Feedback register is trended, discussed at monthly Continuous quality improvement meetings and distributed to staff.
* Education has been provided to staff in relation to feedback, suggestions, complaints and advocacy services.
* A food focus group has been established.
* Feedback and complaints data are discussed at Residents’ meetings.

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

* Consumers reported feedback and complaints are discussed at Residents’ meetings and said management are always advocating to raise complaints and concerns either via feedback forms, directly with staff or management, or at the meetings.
* Management reported all consumers, staff or representatives who lodge a complaint are contacted to discuss their satisfaction with the resolution process.
* Management provided examples of continuous improvement initiatives that have been implemented because of feedback and complaints.
* Feedback and complaints were logged on a register, including actions taken and how they have been used to improve the quality of care and services.
* The organisation has policies and procedures in place to guide staff in relation to feedback and complaints.

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

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# STANDARD 8 Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Assessment Team assessed Requirement (3)(d) in Standard 8 Organisational governance. All other Requirements in this Standard were not assessed; therefore, an overall rating of the Standard is not provided.

Requirement (3)(d) was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate risk management systems and practices were effective in managing and preventing incidents. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service does not meet Requirement (3)(d) in Standard 8, as the service was unable to demonstrate risk management systems and practices were effective in managing high impact or high prevalence risk associated with the care of consumers.

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 compliant with Requirement (3)(d). I have provided reasons for my findings under the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) 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.*

This Requirement was found non-compliant following a Site Audit conducted on 28 April 2021 to 30 April 2021, as the service was unable to demonstrate risk management systems and practices were effective in managing and preventing incidents. The Assessment Team’s report for the Assessment Contact conducted on 22 February 2022 provided evidence of actions taken in response to the non-compliance, including:

* Risk management and incident policies and procedures have been updated to incorporate legislative changes in relation to the Serious Incident Response Scheme.
* Education has been provided to staff in relation to risk management, documentation for incident reporting, duty of care and negligence, falls and near misses.
* An investigation has been undertaken in relation to consumers rolling out of bed, which identified contributing factors can include unmet needs, such as hunger and toileting. Processes have been implemented to ensure staff offer consumers a drink and a snack through the night if they wake and check on continence needs more frequently.
* Floor line beds have been assessed and implemented for two consumers which have reduced their incidents of rolling out of bed.
* Work instructions have been implemented to reflect appropriate timings for neurological observations post falls.

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

* Information and evidence presented by the Assessment Team under Requirement (3)(b) in Standard 3 Personal care and clinical care, demonstrated gaps in staff practice in relation to wound management, pressure area care and post falls management, which were not identified through the organisation’s risk management systems.
* Monthly clinical governance and clinical staff meetings include discussion regarding falls, wounds, infections, behavioural incidents and reportable incidents, however, consideration of the cause of incidents is not always evident.
	+ Consumer B’s wound was reported with a notation they were receiving antibiotics. The meeting minutes did not record discussion of the cause of the wound or strategies to prevent further similar wounds from occurring.

The Assessment Team provided the following evidence demonstrating how the service understands and applies this Requirement:

* The organisation’s incident management system includes a risk register which identifies individual risk for some consumers, including falls and mobility, consumer choice and infection.
* Staff described the action they would take if they observed an incident involving consumers, including falls and abuse.

The provider did not disagree with the Assessment Team’s findings and the provider’s response includes evidence of actions taken in response to deficiencies identified, which include, but are not limited to:

* Implementation of work instructions to ensure a consistent approach to wound management, pressure area care and post fall observation.
* Education has been provided to staff in relation to wound management, pressure area care and neurological observations.
* The Clinical governance committee has been amalgamated with the Quality/WHS committee to ensure clinical care is assessed at a strategic level and the need for additional governance and gap identification tools for the delivery of clinical care is assessed and implemented where needed.

I acknowledge the provider’s response an associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates the service is compliant with this Requirement.

I have considered that information and evidence presented in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care indicates areas for improvement in relation to best practice care, rather than ineffective management of high impact or high prevalence risks associated with the care of consumers. The service’s failure to identify best practice care was not always being provided to consumers relates to deficiencies in the organisation’s clinical governance framework, not risk management systems. I find this information and evidence is more aligned with Requirement (3)(e) in this Standard, which was not assessed at the Assessment Contact.

I have also considered that it is not proportionate to suggest the organisation’s risk management framework is ineffective based the service’s failure to identify the cause of one consumer’s wound or consider strategies to prevent further wounds from occurring.

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 8 Organisational governance.

# Areas for improvement

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

**Standard 1 Requirement (3)(c)**

* Ensure consumers are supported to exercise choice in relation to when they can receive visitors.
* Review processes, policies and procedures relating to supporting consumers to exercise choice and independence.

**Standard 2 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to initiate assessments and develop and/or update care plans, including in relation to wounds, falls and chemical restraint.
* Ensure consumer care plans are updated in response to consumers’ changing condition and clinical incidents.
* Ensure policies and procedures in relation to assessment and planning are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment and planning.

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

* Ensure staff have the skills and knowledge to identify and report maintenance needs for actioning.
* Ensure preventative maintenance processes are in place for common areas.