St Paul's Lutheran Hostel

Performance Report

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**Commission ID:** 6157

**Provider name:** St Paul's Lutheran Homes Hahndorf

**Site Audit date:** 30 September 2020 to 2 October 2020

**Date of Performance Report:** 12 February 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | 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) | Non-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** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | 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) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit 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 Site Audit report received 29 October 2020
* the Review Audit Decision for the Review Audit conducted on 29 to 31 October 2019.

# STANDARD 1 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 Compliant as six of the six specific Requirements have been assessed as Compliant.

Requirement (3)(d) in this Standard was found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. Based on the Assessment Team’s report and the Approved Provider’s response I find this Requirement Compliant and have provided reasons for my finding in the respective Requirement below.

The Assessment Team found most consumers and representatives interviewed consider consumers are treated with dignity and respect, feel consumers can maintain their identity, and consumers can make informed choices about the care and services they receive and live the life they choose. Specific examples include:

* Consumers and representatives confirmed staff treat consumers with respect, including recognising and supporting consumers’ identity.
* Consumers confirmed staff understood their cultural identity and provide appropriate support.
* Consumers and representatives indicated consumers are supported to make decisions about their care, including when others should be involved, and to maintain relationships.
* Consumers and representatives confirmed they receive information from staff and management through several mediums of communication.

Staff interviewed spoke respectfully about consumers and were able to describe individual consumers’ backgrounds, cultural, spiritual, and social needs and preferences. Staff were able to describe how they support consumers to make decisions about their own care and provided information about how they support a consumer to minimise risks associated with the consumer engaging in activities of their choosing to enable them to live the best life they can. Staff were able to describe how they consistently communicate with consumers and representatives and confirmed that consumers’ personal information is kept confidential.

The Assessment Team observed staff interacting with consumers respectfully and providing consumers with appropriate assistance. They also observed various information displayed around the service to inform consumers and representatives about relevant information. Consumers and visitors have access to various areas within the service to sit and talk in private.

Consumers’ care files included information about consumers’ backgrounds, life stories, interests and preferences. The files also showed consumers’ cultural and social needs and preferences are identified, with the lifestyle activity calendar showing the service regularly supports consumers to attend activities relevant to their preferences. The service provides consumers with an admission pack on entry to the service which contains relevant information and hold regular resident meetings to disseminate information.

## 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) 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.*

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

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

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate risks associated with consumers’ choices were identified and effectively managed. The Assessment Team found actions were implemented to address the deficiencies identified at the Review Audit. These actions include:

* Conducting risk assessments and risk reviews in consultation with consumers, representatives and relevant health professionals to identify risks associated with activities of their choosing and implementing strategies to mitigate risks.
* Consumers with identified risks associated with activities of their choosing are discussed during clinical and risk management meetings and are also monitored through critical incidents.

The Assessment Team found the service was able to demonstrate effective risk assessment and management for two consumers engaging in activities of their choosing, including for one consumer who was identified during the Review Audit as not being supported to manage risks associated with an activity of their own choosing. Documentation indicates both consumers have been assessed, consulted and strategies implemented to mitigate identified risks to support these two consumers to live the best life they can.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 1 Requirement (3)(d).

### 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 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 Compliant as five of the five specific Requirements have been assessed as Compliant.

Requirement (3)(d) in this Standard was found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. Based on the Assessment Team’s report and the Approved Provider’s response I find this Requirement Compliant and have provided reasons for my finding in the respective Requirement below.

The Assessment Team recommended Requirement (3)(c) in this Standard as not met. Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view in relation to the Assessment Team’s recommendation and find Requirement (3)(c) in this Standard Compliant. I have provided reasons for my finding in the respective Requirement below.

The Assessment Team found overall, consumers considered the service had identified their needs, goals and preferences and tailored their care accordingly. Specific examples include:

* Consumers and representatives confirmed consumers’ individual risks have been identified and used to inform care and services.
* Consumers interviewed confirmed their needs, goals and preferences had been recognised by the service. They also confirmed their wishes in relation to how and who they want included in assessment and planning was honoured by staff.
* All representatives confirmed they had been notified of changes in care delivery and when incidents had occurred.

Staff interviewed were able to describe assessment and care planning processes, including that they have access to consumer care plans and associated documentation. Staff confirmed care plans direct the delivery of care and services and that consumers and relevant others, such as representatives were informed of care plan reviews, assessment outcomes and changes in consumers’ care and services. Staff were familiar with the service’s care plan and incident review processes.

Consumer files viewed demonstrated a range of clinical, personal and lifestyle assessments were completed on entry and had been routinely reviewed every six months or when changes were identified. Most consumers’ care plans were individualised and reflected consumers’ current needs, goals and preferences. All files viewed included consumers’ end-of-life wishes.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

### 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.*

The Assessment Team found the service was unable to demonstrate processes have been effective in relation to establishing ongoing partnership during assessment and planning processes. The Assessment Team provided the following findings and evidence in relation to their recommendation of not met in this Requirement:

* Five representatives indicated they are not satisfied they are involved or consulted during care plan review processes.
  + One representative (A) indicated they had not been involved during the care plan review process but when they were included in a care plan review, they were not a partner in the process but rather were told about the care plan review.
  + One representative (B) indicated they had not been consulted or advised of the care plan review process.
  + Three other representatives confirmed they were informed retrospectively of changes to care and services, such as following incidents and care plan reviews and considered they were not engaged in a partnership with the service.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The Approved Provider asserts there have been significant improvements in both care plan management and communication with consumers and families in relation to reviewing care plans at any time and being provided with a copy of care plans. The Approved Provider included the following information and evidence relevant to my finding:

* In relation to representative A, progress notes and care plans indicated ongoing communication and discussion in relation to the relevant consumer’s care. It demonstrated the substitute decision maker for the consumer (who is not representative A) has been consulted with during care plan reviews. It also demonstrated representative A corresponds directly via email with the service and is included in discussions about the consumer’s care.
* In relation to representative B, emails from the family indicate there are three adult children of the consumer who have input into their parent’s care, with representative B being the primary contact. The service asserts all three adult children share information and two of three adult children (one being representative B) are included on regular communication emails and communications about their parent.
* A reminder was sent to consumers and representatives on 8 October 2020 re-affirming that consumers can access, review or meet with a clinical team member in relation to their care plan at any time.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Compliant with this Requirement.

In coming to my finding, I have considered that the representatives specifically identified by the Assessment Team have had information shared with them, have been asked to provide feedback and have discussions with relevant staff when they raise a concern. Evidence in the Assessment Team’s report also indicates clinical staff communicate with consumers and/or representatives on a regular basis and when things change. While representatives indicated they are informed in retrospect, such as after a care plan reviews or an incident, this does not suggest representatives are not fully consulted or encouraged to provide feedback during these processes and may indicate that clinical staff undertake assessment processes prior to engaging with consumers/representatives to ensure the conversation in relation to care planning is based on assessed needs.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 2 Requirement (3)(c).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate that outcomes of assessment and planning are effectively communicated to the consumer or is documented in a care plan that is readily available to the consumer. The Assessment Team found actions were implemented to address the deficiencies identified at the Assessment Contact. These actions include:

* Consumer and representative access to care plans had been highlighted and discussed at resident meetings and email correspondence from the CEO.
* Information in relation to care plans, such as review processes and consumer access, had been included in resident meetings and the resident handbook.
* Weekly emails are being sent to representatives to enhance communication and appointed representatives are now contacted by phone following any clinical changes to consumers’ health.
* An ‘evaluation of care plan checklist’ has been created which includes a mandatory comments section for family.
* The Assessment Team found that two consumers and five representatives confirmed they had been informed of the outcomes of assessment and planning and any relevant changes. Three representatives said they had been provided with a copy of the relevant care plan, but the Assessment Team interviewed four consumers who had wanted a copy of the care plan but had not requested it.
* Staff confirmed outcomes of assessment and planning are communicated to consumers and/or representatives and was mostly reflected in care planning documentation.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 2 Requirement (3)(d).

### 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 two of the seven specific Requirements have been assessed as Non-compliant.

Requirements (3)(a), (3)(b) and (3)(g) in this Standard were found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. The Assessment Team found the service had implemented actions and improvements to rectify the deficiencies identified at the Review Audit. These actions include (but are not limited to):

* The service updated its risk-taking procedure, including assessments and authorisation forms. These forms have been completed for consumers living in the memory support unit.
* Complex health management folders were developed for each area of the service and includes a consumer list with clinical issues, such as diabetes status, blood glucose monitoring and insulin administration.
* Regular training sessions for clinical and care staff have been held in relation to a variety of clinical areas.
* A roster review was undertaken to ensure the appropriate number and mix of staff were available to meet consumers’ needs. This review resulted in removal of medication-competent care staff roles, with all medication responsibilities now allocated to enrolled and registered nurses.
* Kits to manage very low blood glucose levels have been created and are stored in the nurses’ station.
* Consumers with low low beds have been assessed and now have bed height indicator tags, crash mats and bed sensors to promote safety. Staff interviewed are aware of safety processes used for consumers with low low beds.
* A monthly risk management meeting is held to discuss risks associated with consumers’ care.

The Assessment Team have recommended Requirement (3)(g) in this Standard as met. Based on the Assessment Team’s report and the Approved Provider’s response I find this Requirement Compliant and have provided reasons for my finding in the respective Requirement below.

While the Assessment Team acknowledged the improvements implemented in relation to Requirements (3)(a) and (3)(b) in this Standard, the Assessment Team found not all consumers are provided with safe and effective personal and clinical care or that high impact or high prevalence risks associated with consumers’ care is effectively managed. The Assessment Team have recommended both Requirements as not met. Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant in relation to Requirements (3)(a) and (3)(b) in this Standard. I have provided reasons for my finding in the respective Requirements below.

The Assessment Team found most consumers consider they receive personal and clinical care which is safe and right for them. Specific examples include:

* Consumers confirmed they receive the care they need and felt staff know their needs and preferences in relation to care.
* Representatives interviewed were satisfied staff respond to consumers’ specific clinical needs.
* Two representatives confirmed staff take appropriate and timely action in response to changes in consumers’ health and incidents.
* Consumers and representatives confirmed they have regular input from the multidisciplinary team and have access to medical officers and allied health professionals when required.

Staff interviewed were aware of consumers’ needs and were able to describe actions taken in response to changes in consumers’ health and well-being. Care staff reported that where changes to consumers’ health were escalated, clinical staff always acted on their reports. Staff confirmed changes to consumers’ care and services are communicated through handovers, clinical care meetings and electronic care system messaging and referrals are made in accordance with consumers’ needs and preferences. Staff demonstrated knowledge and understanding of infection control practices.

The Assessment Team observed consumers to have been provided with appropriate personal care. Consumers’ care files included referrals to a variety of health professionals and recommendations and directives have been incorporated into care plans. Care files also showed that when consumers were suspected of an infection requiring isolation, this was effectively managed. Infections are recorded on a register which is reviewed by clinical staff.

**Assessment of Standard 3 Requirements**

### Requirement 3(3)(a) Non-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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate that blood glucose monitoring for consumers living with diabetes and restraint management was in accordance with medical directives or best practice. The Assessment Team found that while the service has made some improvements following the Review Audit, the service did not ensure each consumer receives clinical care that is best practice, tailored to consumers’ needs or optimises consumers’ health and well-being. Specifically, the Assessment Team found diabetic management plans did not reflect or promote best practice, contain sufficient information for the management of diabetes and staff had not adhered to relevant policy or management plan directives. The Assessment Team provided the following information and evidence relevant to my finding:

* Three consumers’ diabetic monitoring plans did not have clear indications of frequency of monitoring the consumers’ blood glucose levels.
* Eighteen consumers living with diabetes did not have desired blood glucose ranges recorded in the diabetic management plan.
* Two consumers’ diabetic management plans have not been developed in accordance with best practice guidelines.
* Three consumers have not had their diabetes managed effectively or in accordance with consumers’ specific management plans or the service’s policy.
* Six clinical staff interviewed were unable to describe the service’s policy/procedure associated with diabetes management.

The Approved Provider’s response included a list of corrective actions taken in response to the Assessment Team’s report. These actions include but are not limited to:

* All medical officers have been informed they are required to reassess relevant consumers’ diabetic management plans. All relevant diabetic management plans have been updated.
* A training session for all enrolled and registered nursing staff was completed in relation to diabetes management, including the diabetes emergency flow chart.
* Complex health folders have been updated to include all current diabetic management plans, with emergency plans for very-high and very-low blood glucose readings.

I acknowledge the service’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, I find at the time of the Site Audit, the service had not managed consumers’ diabetes in accordance with best practice guidelines, consumers’ diabetic management plans or the service’s policies and procedures. I have considered that staff have not always ensured effective monitoring for consumers with identified elevated blood glucose levels and symptoms associated with high blood glucose levels.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Non-compliant with Standard 3 Requirement (3)(a).

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

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

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate that physical restraint used in the home had been recognised by staff and management, and that when physical restraint was used risk assessments were not always completed or strategies used to promote safety and minimise risk had not always been implemented. The Assessment Team found that while the service has made some improvements following the Review Audit, the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Specifically, the Assessment Team found the service did not consider the use of psychotropic medication as restraint, and consequently did not have associated risk assessments or authorisations completed. Additionally, consumers with hydration risks were not effectively managed or monitored and staff practices were not in accordance with the service’s policy in relation to consumer weight loss and conducting neurological observations following incidents of falls. The Assessment Team provided the following information and evidence relevant to my finding:

* Eight consumers’ files indicated these consumers as having been prescribed regular or ‘as required’ psychotropic medications but did not include medical officer assessment as to the requirement and indication for use of this medication or evidence of consumer and/or representative consent prior to use in accordance with legislative requirements.
* Two consumers who had been commenced on fluid restrictions to manage specific medical conditions, did not have their fluid intake effectively monitored by staff.
* One representative was not satisfied with the management of their consumer’s nutrition and hydration needs.
* Four consumers had either not been weighed monthly or in accordance with specialist directives, or the clinical nurse had not been notified of weight loss in accordance with the service’s policy. Where the clinical nurse had not been notified appropriate investigation into the weight loss had not occurred and subsequent interventions implemented.
* Two consumers who had sustained several falls did not have neurological observations completed in accordance with the service’s policy. Clinical staff were unable to demonstrate knowledge of the frequency neurological observations should be taken following a consumer having a fall.
* The Approved Provider’s response included a list of corrective actions taken in response to the Assessment Team’s report. These actions include but are not limited to:
* Updated the restraint minimisation and management procedure.
* Provided examples of five consumers who are prescribed antipsychotic medication, including consultation with consumers/representatives and the medical officer indicating the reason and use for the medication.
* A message was sent to staff via the service’s electronic care system in relation to management of consumers with fluid restrictions.
* Staff have participated in training in relation to nutrition, hydration and weight monitoring. Consumers identified in the Assessment Team’s report with weight loss have been referred to appropriate specialists and have had appropriate monitoring processes implemented.
* Staff have been provided with information and education sessions in relation to post falls management.

I acknowledge the service’s actions and improvements to rectify the deficiencies identified by the Assessment Team. I also acknowledge that the Assessment Team found the service effectively managed high impact or high prevalence risks in relation to behavioural management, wound management and pressure injuries. However, I find at the time of the Site Audit, the service had not effectively managed consumers’ use of psychotropic medication, fluid restrictions for medical conditions, weight loss or post falls management either in accordance with directives, policy or legislation. I consider that the ineffective management of these areas do not support that the service effectively manages high impact or high prevalence risks associated with the care of each consumer.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Non-compliant with Standard 3 Requirement (3)(b).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate practices to promote appropriate antibiotic use and reduce the risk of increasing resistance to antibiotics had been implemented.

* The Assessment Team found the service was able to demonstrate effective standard and transmission based precautions in relation to two consumers who had been placed into isolation due to potential infection and had a range of measures and plan to respond to the COVID-19 global pandemic.
* The Assessment Team also found most clinical and care staff demonstrated knowledge and understanding of infection control principles and could describe practical strategies used to minimise the spread of infection.
* Clinical staff demonstrated knowledge of antimicrobial stewardship, including describing strategies used to reduce antimicrobial resistance. Staff also confirmed they have participated in training related to antimicrobial stewardship.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 3 Requirement (3)(g).

# 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, most consumers and representatives interviewed consider consumers get the services and supports for daily living which are important for their health and well-being and enable them to do the things consumers want to do. Specific examples include:

* Consumers confirmed staff support them to do the things they like to do and are important to them, including maintaining independence with daily tasks and attending activities of their choice within and outside the home.
* Consumers interviewed indicated staff are attentive to consumers’ emotional and psychological well-being.
* Consumers and representatives provided examples in relation to how consumers are supported to maintain relationships which are important to the consumers.
* Consumers indicated they are satisfied with the meals provided, including the quality and quantity of meals and food.

Staff interviewed were able to describe how they support consumers to do things which are important to the consumers, including various activities, maintaining relationships and participating in the community, within and outside the service. Staff were also able to describe strategies they use to support consumers’ emotional needs and have access to information to understand consumers’ needs and preferences. Staff were able to describe how specific consumers’ food needs and preferences are supported, including the provision of alternatives to main meals. Staff indicate they have access to relevant information to enable them to provide care and services.

The Assessment Team observed consumers participating a variety of activities throughout the Site Audit and meal service in the memory support unit was calm with staff gently supporting and encouraging consumers to eat and drink. Equipment used to support consumers appeared to be safe, clean and well-maintained and the kitchen was clean and tidy, with staff using appropriate food safety practices when serving food.

Consumers’ care plans include information about consumers’ emotional, spiritual and psychological well-being, including things which are important to consumers. The service’s activity program indicates a wide-range of activities are offered and the menu shows consumers are offered a variety of meal options.

## 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 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 Compliant as three of the three specific Requirements have been assessed as Compliant.

Requirement (3)(b) in this Standard was found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. Based on the Assessment Team’s report and the Approved Provider’s response I find this Requirement Compliant and have provided reasons for my finding in the respective Requirement below.

The Assessment Team found overall, consumers interviewed consider they feel they belong in the service and feel and safe and comfortable in the service environment. Specific examples include:

* Consumers indicated they find the service environment welcoming, comfortable and easy to navigate.
* Consumers confirmed they are able move freely both indoors and outdoors, including those who use mobility-assisting aids.

Staff interviewed described how they make consumers feel at home and how they support consumers to maintain their independence within the service environment. Staff described cleaning and maintenance processes used to ensure the service’s environment and equipment is maintained.

The Assessment Team observed the service environment to be welcoming and have a home-like feeling. It was also observed to be safe, clean and well-maintained with consumers in all areas being able to be move freely both indoors and outdoors. Furniture, fittings and equipment were observed to be safe, clean, well-maintained and suitable for consumers.

The service has a documented preventative and reactive maintenance program which includes regular actions to ensure the safety and comfort of the environment. The Assessment Team found these programs were effectively implemented.

## 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) 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 to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate consumers living in the memory support area were able move freely both indoors and outdoors. The Assessment Team found actions were implemented to address the deficiencies identified at the Review Audit. These actions include:

* The service’s external door security policy was reviewed and updated.
* Automatic doors leading to the garden in the memory support unit have been programmed to automatically unlock in the morning and secure at night.
* Risky activity/restraint authorisations and assessments in relation environmental restraint have been completed for consumers living in the memory support unit.
* Consumers’ barn doors which were previously used as behavioural management strategies are no longer used and allow consumers to move freely in and out of their rooms.

The Assessment Team found consumers interviewed confirmed they were able to move both freely indoors and outdoors and observed the doors to the outside area of the memory support area to be unlocked during the Site Audit. The Assessment Team also observed the service environment to be safe, clean and well-maintained, with all consumers in all areas of the home being able to move freely, both indoors and outdoors.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 5 Requirement (3)(b).

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

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

# STANDARD 6 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 Compliant as four of the four specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers interviewed consider they are encouraged and supported to provide feedback and make complaints, and that appropriate action is taken. Specific examples include:

* All consumers and representatives interviewed said they feel comfortable to raise concerns with management and are encouraged to provide feedback.
* Representatives interviewed indicated they are aware of how to access external complaints and advocacy services.
* Consumers confirmed the service responds to their concerns immediately and use open disclosure processes when required.
* Two representatives indicated they are in current communication with management to resolve their concerns, with one representative confirming some improvements made to date in response to their concerns.
* Consumers believe the service makes changes because of feedback and complaints, including receiving follow-up surveys from the service to ensure they are satisfied with the outcome.

Staff interviewed were able to describe processes used if consumers raise issues or concerns and indicated they are encouraged by management to document and raise feedback/complaints on behalf of consumers. Staff indicated information about complaints and advocacy in languages other than English is available and described how they assist consumers with communication or cognitive impairments. Staff were aware of the service’s open disclosure policy and confirmed they have participated in training relating to complaints and open disclosure. Management were able to provide examples of improvements which have been a direct result of feedback.

The Assessment Team observed posters displayed throughout the service with information for consumers and representatives about how to make complaints and provide feedback, including advocacy and interpreting services. Information about internal and external complaints processes are included in the Resident Handbook. The complaints log indicates that management take appropriate action in relation to 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) Compliant

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

# 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.

Requirements (3)(a), (3)(c) and (3)(e) in this Standard were found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. Based on the Assessment Team’s report and the Approved Provider’s response I find these Requirements Compliant and have provided reasons for my finding in the respective Requirement below.

The Assessment Team found overall, consumers interviewed consider they receive quality care and services when they need them and from people who are knowledgeable, capable and caring. Specific examples include:

* Consumers and representatives indicated they are generally satisfied with the responsiveness of staff in relation to answering call bells.
* Consumers and representatives interviewed were satisfied with staff’s responsiveness to consumers’ needs and feel that staff know what they are doing.
* Consumers and representatives provided examples of staff being kind, caring and respectful. However, one representative did indicate they felt staff did not demonstrate patience or a positive attitude.
* Consumers and representatives indicated staff are knowledgeable and feel staff know what they are doing, with one representative noting an improvement in staff skills and management responsiveness to any concerns.

The Assessment Team observed staff interactions to be kind, caring and respectful. Staff were observed chatting with consumers in a cheerful manner and providing gentle guidance to consumers returning from activities.

Staff interviewed confirmed they have sufficient time to complete their duties within their allocated shift and feel supported by managers, including participating in numerous training and mentoring opportunities. Care staff said they have received training in relation to all aspects of the Quality Standards and that their knowledge has been tested through assessments following training.

The Assessment Team reviewed the organisation’s feedback register and found a recent consumer survey which identified the service have followed-up feedback in relation to staff language/communication issues. Training records indicate all staff actively working at the service have completed mandatory training and that the training plan is developed based on the needs of staff.

## 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate staff numbers were sufficient to ensure consumers’ call bells were answered in a timely manner to ensure the delivery of safe and quality care. The Assessment Team found actions were implemented to address the deficiencies identified at the Review Audit. These actions include:

* A roster review was undertaken to ensure appropriate skill mix and numbers of staff were being rostered.
* A recruitment and onboarding policy and procedure was developed to ensure the most appropriate staff were being employed and job descriptions and duty statements were reviewed to ensure staff understand their role and associated expectations.
* A new call bell system has been installed which allows the service to monitor call bell response times, including weekly reports which are reviewed at leadership meetings.
* All consumers have been issued with pendants or watches which are connected to the new call bell system and staff wear electronic fobs.
* The service has implemented a call bell escalation process and call bell response times are measured against a key performance indicator (KPI), with any call bells over the KPI followed-up with staff on duty.

The Assessment Team found consumers and representatives were generally satisfied with the responsiveness of staff in relation to answering call bells. Two representatives indicated slow call bell response times had occurred but there is no further detail indicating negative impact to consumers, nor did call bell response time data indicate a systemic issue. Representatives said they had noted an increase in staff numbers since the new management team commenced and overall, the care and general atmosphere has improved.

Staff interviewed were complimentary of the new call system and confirmed they have sufficient time to complete their work within their allocated shift.

The Assessment Team viewed the service’s allocation sheets and roster for a two-week period and found unplanned leave for clinical and care shifts were replaced.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 7 Requirement (3)(a).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate staff performed their role effectively in relation to several aspect of clinical care or that staff could effectively communicate with consumers. The Assessment Team found actions were implemented to address the deficiencies identified at the Review Audit. These actions include:

* Significant changes to the service’s management team were implemented.
* New recruitment strategies have been developed and implemented to ensure appropriate staff are employed, including ensuring staff have the required English skills to effectively communicate with consumers.
* Orientation and training processes have been reviewed with a new online training program implemented and new probationary periods and processes for new staff.
* New consumer surveys have been implemented to seek consumers’ satisfaction and feedback about staff skills.
* A training program relevant to the clinical deficits identified at the Review Audit was implemented to enforce staff understanding and skills.

The Assessment Team found all consumers and representatives interviewed said staff are knowledgeable and do their jobs to the best of their ability. Consumers said they feel staff know what they are doing and trust staff to care for them.

A new member to staff confirmed the service’s new recruitment and probation processes, and indicated they were well-informed of the service’s expectations and requirements of the role. Staff interviewed confirmed duty statements and job descriptions are reflective of their roles and feel supported to perform their roles effectively.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 7 Requirement (3)(c).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate two staff were managed and monitored in accordance with the service’s performance management and disciplinary processes in relation to allegations of rough handling. The Assessment Team found actions were implemented to address the deficiencies identified at the Review Audit. These actions include:

* The annual staff appraisal process has been reviewed and processes implemented to ensure these are conducted in a timely manner. Evidence was provided that staff appraisals have been completed and training for individual staff and professional development has been identified.
* New probationary performance processes for new staff have been implemented which includes three and six-monthly reviews.
* Clinical staff actively monitor staff performance and identify areas of improvement which are addressed with group or individual training.

Staff interviewed confirmed they attend annual performance reviews where they speak with their relevant manager to discuss their performance, make suggestions for training and identify areas for further support. Clinical staff indicated management regularly monitor staff practices through observation, incident reporting, and appraisal and feedback processes.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 7 Requirement (3)(e).

# 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 two of the five specific Requirements have been assessed as Non-compliant.

Requirements (3)(c), (3)(d) and (3)(e) in this Standard were found to be Non-compliant following a Review Audit conducted on 29 to 31 October 2019. The Assessment Team found the service had implemented actions and improvements to rectify the deficiencies identified at the Review Audit. These actions include (but are not limited to):

* Policies in relation to the use of physical restraint have been reviewed.
* A clinical governance framework has been developed and staff interviewed were aware of associated policies which are relevant to their roles.
* The open disclosure policy was reviewed and updated, and staff demonstrated an understanding of this policy.

While the Assessment Team acknowledged the improvements implemented in relation to Requirements (3)(c), (3)(d) and (3)(e) in this Standard, the Assessment Team have recommended these Requirements as not met. The Assessment Team have also recommended Requirement (3)(a) in this Standard as not met. The Assessment Team found the service was unable to demonstrate consumer engagement strategies include consumers in decision-making processes, effective governance processes in relation to regulatory compliance, effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers and were unable to demonstrate effective processes in relation to minimising the use of restraint and open disclosure. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant in relation to Requirements (3)(d) and (3)(e) in this Standard. However, I have come to a different view in relation to the Assessment Team’s recommendation of not met for (3)(a) and (3)(c) in this Standard and find these Requirements Compliant. I have provided reasons for my findings in the respective Requirements below.

The Assessment Team found the organisation was able to demonstrate their governing body promotes a culture of safe, inclusive and quality care and services and is accountable for delivery. The Board receives monthly reports from the CEO in relation the performance of the service, feedback and complaints, Board subcommittee reports in relation finance and risk, clinical care, property development, strategy, policy and marketing.

## 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.*

The Assessment Team found the service was unable to demonstrate consumer engagement strategies include consumers in decision-making processes. The Assessment Team provided the following findings and evidence in relation to their recommendation of not met in this Requirement:

* Consumers are encouraged to provide feedback to the organisation about the delivery of care and services but are not actively engaged in the development of these services.
* The service has regular resident committee meetings to discuss various aspects of the service and care delivery, however, feedback is in relation to actions already implemented.
* Surveys are undertaken in response to complaints or when the service requires feedback.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The Approved Provider asserts the service provides consumers and representatives with considerable engagement and opportunity to contribute to the development, delivery and evaluation of services. The Approved Provider included the following information and evidence relevant to my finding:

* While there is no specific Resident Committee, the service’s regular resident meetings are structured in a manner which encourages consumer engagement and input into a wide range of services.
* At a resident meeting in October 2020, consumers were asked about the introduction of resident representative group and the results show no consumers of 27 present supported the introduction of such a group. Consumers confirmed they were satisfied the resident meeting is the best forum to raise issues, suggestions and ideas.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Compliant with this Requirement.

In coming to my finding, I have considered the evidence provided by the Approved Provider, including resident meeting minutes, which indicate a significant number of consumers attend the meeting, have several opportunities to provide feedback and comment in relation to various issues, care and services. While these meetings do include feedback on processes and services already implemented within the service, I find consumers input at the regular resident meeting is considered and used to develop, deliver and evaluate care and services.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 8 Requirement (3)(a).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate effective regulatory compliance systems, specifically that management and staff comply with legislative requirements in relation to compulsory reporting of allegations or suspicions of consumer assault. The Assessment Team found the service demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, and feedback and complaints. However, found that regulatory compliance systems remained ineffective. The Assessment Team provided the following findings and evidence in relation to their recommendation of not met in this Requirement:

* Eight consumers’ files indicated these consumers as having been prescribed regular or ‘as required’ psychotropic medications but did not include medical officer assessment as to the requirement and indication for use of this medication or evidence of consumer and/or representative consent prior to use in accordance with legislative requirements.
* The Approved Provider’s response included a list of corrective actions taken in response to the Assessment Team’s report. These actions include but are not limited to:
* Updated the restraint minimisation and management procedure.
* Provided examples of five consumers who are prescribed antipsychotic medication, including consultation with consumers/representatives and the medical officer indicating the reason and use for the medication.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Compliant with this Requirement.

In coming to my finding, I have considered evidence presented by the Assessment Team in relation to regulatory compliance and other governance systems which indicate effective systems. This includes (but not limited to):

* In relation to regulatory compliance, the service now maintains a compulsory reporting log which the Assessment Team found meets legislative requirements.
* In relation to information management, the service provides staff with sufficient and relevant information to support them to perform their roles effectively. The Assessment Team did note that some guidance material used by staff to provide clinical care was vague and non-specific, but I have considered this information in relation to Requirement (8)(e) in this Standard. It was also found consumers are provided with sufficient access to information to make decisions about care and services.
* In relation to continuous improvement, the service has a quality framework, including a continuous improvement plan which has improvements identified through several different sources.
* In relation to financial governance, the service has a standard budget which is monitored and governed by a finance committee and any changes or additional budget items require Board approval.
* In relation to workforce governance, the service demonstrated staff numbers and skill mix are sufficient, with staff supported with ongoing training and performance reviews. Staff were found overall to be competent in relation to performing their roles.
* In relation feedback and complaints, the service demonstrated feedback is used to improve care and services.

While the service has not demonstrated all requirements set out by the *Quality of Care Principles 2014* in relation to use of chemical restraint have been clearly documented or applied, I have considered this information in relation Requirement (3)(e) in this Standard which requires the service to have effective clinical governance processes, including using chemical restraint in accordance with relevant legislation. In considering the Assessment Team’s report and the Approved Provider’s response, on balance of all the evidence presented, I find that overall, the service’s organisation wide governance is effective, including that key governance areas are effective to improve outcomes for consumers. I have found the service to be Non-compliant in relation to Standard 3 Requirements (3)(a) and (3)(b), however, I have considered this information in relation to Requirements (3)(d) and (3)(e) in this Standard which focuses on clinical and risk management frameworks directly relating to the key deficiencies identified in Standard 3.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Standard 8 Requirement (3)(c).

### 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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate the service’s risk register addressed high impact or high prevalence risks associated with diabetes, restraint and consumer choices to live the best life they can. Additionally, staff practices in relation to physical and chemical restraint had not been recognised and an appropriate response in relation to risk implemented.

The Assessment Team found the service was unable to demonstrate effective risk management systems and practices associated with chemical restraint, diabetes, falls and hydration, nutrition management. The Assessment Team provided the following information and evidence relevant to my finding:

* Risk associated with diabetes management have not been effectively managed.
* Chemical restraint used within the service has not been managed in accordance with relevant legislative requirements, specifically in maintaining required documentation.
* Consumers’ nutrition and hydration needs had not been effectively managed in accordance with medical directives or the service’s policies.
* Staff have not completed neurological observations following incidents of falls in accordance with the service’s policies.
* The Approved Provider’s response included a list of corrective actions taken in response to the Assessment Team’s report. These actions include but are not limited to:
* Updated the restraint minimisation and management procedure.
* Provided examples of five consumers who are prescribed antipsychotic medication, including consultation with consumers/representatives and the medical officer indicating the reason and use for the medication.
* A message was sent to staff via the service’s electronic care system in relation to management of consumers with fluid restrictions.
* Staff have participated in training in relation to nutrition, hydration and weight monitoring. Consumers identified in the Assessment Team’s report with weight loss have been referred to appropriate specialists and have had appropriate monitoring processes implemented.
* Staff have been provided with information and education sessions in relation to post falls management.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with this Requirement.

I acknowledge the service’s actions and improvements to rectify the deficiencies identified by the Assessment Team and that the Assessment Team found effective risk management systems and practices in relation to responding to abuse and neglect of consumers and that consumers are supported to live the best life they can. However, I find at the time of the Site Audit, the service had not effectively managed high impact and high prevalence risks associated with the care of several consumers. I consider that staff practices have not been effective in several high risk clinical areas, indicating a systemic issue. I also find the service’s risk management framework have not identified these risks.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Non-compliant with Standard 8 Requirement (3)(d).

### Requirement 8(3)(e) Non-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.*

This Requirement was found to be Non-compliant following a Review Audit on 29 to 31 October 2019 because the service was unable to demonstrate an effective clinical governance framework, specifically in relation to deficiencies associated with understanding of antimicrobial stewardship, minimising the use of restraint and open disclose.

The Assessment Team found the service has a documented clinical governance framework which includes policies relating to antimicrobial stewardship, minimising the use of restraint and an open disclosure policy. However, the Assessment Team found staff practices did not support these policies in relation to minimising the use of restraint and open disclosure. The Assessment Team provided the following information and evidence relevant to my finding:

* Staff did not consider consumers who are prescribed and administered psychotropic medications as being chemically restrained. Subsequently, the service was unable to demonstrate chemical restraint is used in accordance with relevant legislation.
* Staff did not always apply open disclosure processes when things have gone wrong, specifically in relation to clinical incidents not being reported to consumers’ representatives.
* The Approved Provider’s response included a list of corrective actions taken in response to the Assessment Team’s report. These actions include but are not limited to:
* Updated the restraint minimisation and management procedure.
* Provided examples of five consumers who are prescribed antipsychotic medication, including consultation with consumers/representatives and the medical officer indicating the reason and use for the medication
* Open disclosure information sent to representatives indicating consumers are being reviewed for specific medication which could be considered chemical restraint.
* Clinical staff have been reminded through several communications about their role and responsibility of informing relevant representatives about clinical incidents.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with this Requirement.

I acknowledge the service’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, I find at the time of the Site Audit, the service’s clinical governance framework has not been effective to support staff to manage the use of psychotropic medication in accordance with the *Quality of Care Principles 2014*. I have also considered that the service has not always used open disclosure processes in relation to clinical incidents to support consumers/representatives to explain the facts of the incidents and steps taken to prevent the incident from re-occurring.

For the reasons detailed above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Non-compliant with Standard 8 Requirement (3)(e).

# 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.

The service has implemented an action plan to address the deficiencies identified by the Assessment Team and have included improvements which directly address the issues identified by the Assessment Team in the relevant Requirements.

The service should seek to ensure the following:

* **Standard 3 Requirements (3)(a) and (3)(b):**
  + Consumers’ diabetic management plans include all relevant information based on consumers’ medical needs and in accordance with best practice.
  + Staff provide care in accordance with diabetic management plans.
  + Prescribing and administering of medications constituting chemical restraint is in accordance with the Quality of Care Principles 2014.
  + Staff monitor consumers’ fluid intake in accordance with medical officer directives and consumers’ health conditions.
  + Consumers’ weights are monitored in accordance the service’s policies and consumers’ health needs.
  + Consumers’ health status is effectively monitored following incidents of falls, including the completion of neurological observations in accordance with the service’s procedures.
* **Standard 8 Requirements (3)(d) and (3)(e):**
  + The risk management framework monitoring the clinical practices of staff and clinical outcomes for consumers.
  + The clinical governance framework monitors the correct application of the *Quality of Care Principles 2014* in relation to use of chemical restraint, including using it as a last resort and implementing genuine actions to minimise its use. Additionally, open disclosures processes are used for all incidents.