Strathalbyn & District Aged Care Facility

Performance Report

14 Alfred Place   
STRATHALBYN SA 5255  
Phone number: 08 8536 2426

**Commission ID:** 6181

**Provider name:** Barossa Hills Fleurieu Local Health Network Incorporated

**Site Audit date:** 12 April 2021 to 14 April 2021

**Date of Performance Report:** 15 July 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **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) | 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** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-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** | **Non-compliant** |
| Requirement 7(3)(a) | Non-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) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 13 May 2021.

# 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.

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

* are treated with dignity and respect. They said staff understood them as individuals, including their needs and preferences.
* support them to enable them to take risks to live the lives they want.
* respect their privacy and ensure their personal information is kept confidential.
* feel safe at the service and are free to express themselves how they wish, are able to exercise choice and independence and are happy with the information the service provides to enable them to make decisions.

Consumer files sampled showed assessments and care plans documented an understanding of consumers’ needs and expectations with respect to their identify and diversity with assessments identifying consumers’ social details and support network, life and work, past and present interests religious and cultural needs. Staff described how they treat consumers with dignity and respect by understanding individual consumers’ identity, culture and life story and were able to give examples. Observations of staff practice made by the Assessment Team demonstrated staff were mindful and respectful of consumers and their beliefs.

Care planning documents sampled showed specific cultural needs documented and staff sampled said they had undertaken cultural awareness training and were able to describe consumers with differing cultural backgrounds. The procedure to guide lifestyle staff outlines the importance of recognising and celebrating culture for individual consumers to ensure care and services are culturally safe.

Sampled consumers confirmed they are supported to exercise choice and independence. Care planning and lifestyle documentation viewed demonstrated consumers are actively engaged and involved in decision making about their care. Staff could describe how each consumer is supported to make informed choices about their care and services on a day to day to basis. Staff were able to provide examples such as encouraging consumers to select outfits or accessories they would like to wear for the day.

Consumers who choose to take risks have risk assessments completed in line with their goals and preferences. This includes for consumers who have coffee machines and refrigerators in their rooms. Consumers interviewed were satisfied with how the service supports them in exercising choice in relation to their individual risk profile and staff were able to describe how they support individual consumers to take risks.

Consumers are provided information, which is accurate, current, timely and communicated clearly and enables them to exercise choice. The Assessment Team observed staff displaying an understanding of how to maintain confidentiality, such as securing areas of the service that held personal information of consumers. Consumers interviewed confirmed staff respect their privacy when providing care and services.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

### Requirement 1(3)(c) 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.*

### 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.

The Assessment Team found overall, consumers sampled considered that they feel like partners in the ongoing assessment and planning of their care and services. The following examples were provided by consumers during interviews with the Assessment Team:

* all said if they have a specific need or want, they feel comfortable talking to staff, and staff make necessary changes.
* believe they could access care plans if they wanted.
* speak with staff about their needs and preferences and are listened to.
* identified family members involved in care planning and review.

Assessment processes support staff in delivering personal care and clinical care that is tailored to consumers’ needs and optimises their health and well-being. The service has policies and procedures to guide staff with a timeline for assessments requiring completion in the first four weeks when a consumer first enters the service. A range of clinical risk assessment tools are used within the service to assess consumer needs to inform care planning. Documentation sampled showed the service identifies end of life preferences which includes recording advance care directives. Staff interviewed by the Assessment Team could describe consumers’ preferences in terms of personal and clinical care and end of life planning.

Care plans sampled recorded information on who has been identified as the nominated representative and is to be involved in care planning discussions. Nursing and care staff interviewed said they access the care plans electronically, and all staff are notified when changes occur. 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. This occurs according to a set schedule with outcomes and changes discussed through a range of meetings and forums. The Assessment Team found the service has a range of monitoring processes which includes scheduled care and service plan reviews in addition to a range of audits to ensure consumers have relevant assessments and care plans developed in accordance with their needs, goals and preferences.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

## 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.*

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

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

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

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

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

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

* observed staff washing their hands and cleaning their rooms.
* have been referred to allied health staff.
* staff are familiar with their care needs and when changes arise.
* staff know their likes and dislikes.
* are happy with the quality of care given.

Assessment processes identify each consumer’s needs, goals and preferences in relation to end of life, high-impact and high-prevalence risks and infection related risks. Sampled documents showed these are reflected in care planning and assessment documentation. Staff interviewed were able to describe how they provide care and services in accordance with the care and service plan.

Documentation sampled demonstrated where consumers were noted to have deteriorated or had changes to their mental health, cognitive or physical function the service ensured actions were implemented promptly. Clinical staff interviewed said the service is collocated with the hospital, which supports effective management of consumers who deteriorate.

Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation. This includes electronic care and service plans, handover documentation and a range of meetings and forums.

Consumers interviewed confirmed they have access to Allied Health specialists. Documentation sampled showed consumers are referred to a range of health professionals which includes Medical Officers, Physiotherapists, Speech Pathologists, Podiatrists and Dietitians.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

The Assessment Team were not satisfied the service demonstrated each consumer gets safe and effective personal or clinical care that is best practice, tailored to their needs and optimises health and well-being. Deficiencies related to effective behavioural management, identification of triggers and use of chemical restraint. This was evidenced by the following:

* Progress notes and behaviour charts for Consumer A, Consumer B and Consumer C show ongoing responsive behaviours towards other consumers and/or staff in the four weeks prior to the Site Audit with strategies implemented not always being effective.
* Documentation viewed by the Assessment Team indicates the service has been considering referring Consumer B and C to other health and service providers in relation to managing their individual behaviours of concern. However, this has not been actioned. Documentation viewed showed consideration for referral was undertaking 27 and 6 days prior to the Site Audit for Consumer B and C respectively.
* The Assessment Team observed insufficient staff in the memory support unit to implement recommended strategies to manage responsive behaviours for individual consumers as outlined in their care and service plan.
* Staff said their first strategy to manage consumers with responsive behaviours is to isolate the consumer and provide one-to-one care, but there was not always sufficient staff for this, and at times this triggered further responsive behaviours for individual consumers.
* Care files viewed for three consumers with responsive behaviours, including agitation and aggression, demonstrated specific triggers or unmet need were not consistently documented.
* The service has weekly High-Risk Resident Meetings, where strategies to address responsive behaviours are discussed, but this does not always prompt care plan changes, and timely referrals to external services.
* The service did not demonstrate best practice in relation restrictive practices associated with chemical restraint. Three consumers’ files sampled who are prescribed and administered medication in the form of chemical restraint did not have a consent from signed by a representative. Trialled strategies and outcomes were not always documented on charts or progress notes prior to administering medication in the form of chemical restraint. Non-pharmacological interventions used prior to use of chemical restraint were not consistently documented. Triggers and strategies to manage responsive behaviours for individual consumers on relevant documents were not always personalised.

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

* Providing education and training to staff to ensure best practice in the prevention and management of responsive behaviours.
* Reviewing and updating care planning and assessment documentation in relation to managing responsive behaviours.
* Undertake reflective practice exercises to ensure learnings are sustained.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service was not able to demonstrate each consumer gets safe and effective personal or clinical care that is best practice, tailored to their needs and optimises health and well-being. Specifically, in relation to effective management of consumers displaying responsive behaviours, identification of triggers and use of medication in the form of chemical restraint.

In coming to my decision, I noted three consumers displaying ongoing responsive behaviours who did not have specific triggers or unmet needs consistently documented to inform care planning. Observations by the Assessment Team during the Site Audit indicated insufficient staff in the memory support unit to implement recommended strategies which was confirmed through staff interviews.

I acknowledge the service had considered referring Consumer B and Consumer C to specialists for review, however, a referral had not been completed at the time of the Site Audit.

I acknowledge the service has a process for recording information in relation to the use of medication in the form of chemical restraint to guide staff practice. However, documentation viewed for Consumer A, B and C who are prescribed and administered medication in the form of chemical restraint are not administered this medication in accordance with current best practice and in particular trialling alternative strategies and seeking consent.

For the reasons detailed above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 NON-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 Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

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

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

* service supports them to do the things they want to do but allows them to be as independent as possible.
* they do the things of interest to them and are assisted to build and maintain relationships.
* other consumers are nice and enjoy talking to them.
* staff are knowledgeable about their needs and preferences.
* . were overall satisfied with food, including that there is adequate variety and quantity

Initial and ongoing assessment processes identify each consumer’s needs and preferences in relation to services and supports for daily living and are used to inform the care and service plan. Assessment documentation sampled included information on lifestyle preferences, life history and cultural and spiritual needs.

The service maintains a diverse lifestyle activity calendar with activities suitable for consumers with differing needs. This includes a regular early risers program, Tai Chi, men’s cave and a birthday party for consumers at the end of the month.

Consumers are supported to have social and personal relationships both within and outside of the service. Consumers interviewed provided examples about how the service supports them to maintain connections with the community and maintain personal relationships. Staff explained how some consumers have their own mobile phones which they use to connect with friends and family outside the service, and for others they use equipment at the service to call or video call.

Care documents sampled demonstrated information about consumer needs and condition is accurate and accessible when required to inform delivery of care and services. Management interviewed described using a communication book to communicate individual consumer lifestyle needs and preferences.

The service has established networks with external organisations and individuals and refers consumers where appropriate. This includes referrals to volunteer organisations.

Meals provided are of suitable quality and quantity with consumers being able to choose from a seasonal menu. Care planning documents sampled showed information relating to consumer dietary needs and preferences is captured and updated where requirements or circumstances change.

Equipment provided to consumers is maintained, cleaned and stored safely. The Assessment Team observed equipment provided for services and supports to be clean and well maintained. Processes support the scheduled cleaning and maintaining of equipment which is provided to consumers.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care, to be Compliant with Requirements (4)(a), (4)(c), (4)(d), (4)(e), (4)(f) and (4)(g) in Standard 4 Services and support for daily living.

## Assessment of Standard 4 Requirements

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

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

### Requirement 4(3)(b) Non-compliant

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

The Assessment Team were not satisfied the service demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. Deficiencies related to services and supports in relation to the provision of spiritual and religious services to promote well-being. This was evidenced by the following:

* Consumer B and representative of Consumer A were not satisfied with the provision of spiritual and religious services at the service as they had been ceased due to COVID-19. Both described the impact on well-being of not having those services available and were disappointed in how the service had managed the provision of spiritual and religious services.
* Consumer files viewed for Consumer A and Consumer B showed spirituality and pastoral support is important to both consumers in addition to partaking in religious services including communion.
* A clinical staff member described how the service ‘hadn’t had a service for a long time’ and were able to identify consumers who had a strong religious affiliation including Consumer A.
* A care staff worker said they were not aware of how the service was meeting individual consumers’ spiritual needs.
* Management indicated the service does not currently hold group activities of a religious nature due to SA Health directives. COVID-19 restrictions had prevented volunteers from visiting the service, including those from church groups to provide pastoral care. In the last 12 months, the service has been constrained on what activities can be provided, however, tries to schedule use of spiritual music (such as hymns) at least weekly, generally on a Sunday.
* Prior to the impact of COVID-19, the worship roster showed six Christian denominations were attending the service.

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

* Investigate alternatives for all non-face-to-face Spiritual Service Delivery options to ensure each consumer’s spirituality and faith is supported.
* Management to participate in planning alternatives to provision of care in response to the impact of Government directives.
* Undertake a review and update as required through an audit process of all consumers’ Spiritual and Cultural Needs and Emotional Assessments.
* Develop a Pastoral Care Roster/Schedule to support the provision of regular multi-denominational services and provide relevant education to staff.
* Provide education to staff on the implementation of a Religious Register and further training on Spirituality.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service was not able to demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. Specifically in relation to services and supports promoting the well-being of consumers who have identified spiritual needs, goals and preferences.

In coming to my decision, I have placed weight on the feedback provided to the Assessment Team from Consumer B and the representative of Consumer A, with respect to the impact to their well-being following cessation of their pastoral and spiritual services. In addition, consumer files viewed for Consumer A and Consumer B showed spirituality and pastoral support is important to both consumers in addition to partaking in religious services. I acknowledge the service’s response in relation to the State Government Directions and the impact of COVID-19, however the service did not demonstrate they had attempted to arrange suitable alternatives for both Consumer A and Consumer B, to ensure their spiritual needs, goals and preferences were being addressed to promote their well-being

For the reasons detailed above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Non-compliant with Requirement (3)(b) in Standard 4 Services and support for daily living.

### 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.

The Assessment Team found consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. The following examples were provided by consumers during interviews with the Assessment Team:

* is welcoming and a nice place to live.
* is well maintained and requested maintenance is addressed promptly.
* can access both indoor and outdoor areas freely when they want to.

The service environment was observed by the Assessment Team to be welcoming and easy to navigate and optimises the consumer’s sense of belonging, independence, interaction and function. The service currently comprises a single-level with four wings which includes one secure memory support unit. The Assessment Team observed the service entrance to be welcoming, with a reception desk and staff present to assist with the sign-in process. Consumers are oriented to the service when they first enter by staff and other consumers. Observations by the Assessment Team indicated consumers are supported to individualise their rooms with personal belongings, and communal areas were decorated with items reflective of the consumer cohort.

The service environment, furniture and fittings were observed by the Assessment Team to be safe, clean and well maintained. Staff interviewed confirmed maintenance requests are made via an online form, or hard copy where needed and are addressed promptly. Observation by the Assessment Team demonstrated consumers are able to move freely both indoors and outdoors. Monitoring processes include a range of audits, feedback mechanisms and monthly Work Health and Safety meetings to ensure the environment, furniture and fittings are safe, clean and well maintained.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

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

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

### Requirement 5(3)(b) Compliant

*The service environment:*

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

### 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, sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* are overall happy with care and services and management are responsive to feedback which includes feedback on meal services.
* Feel comfortable to raise their concerns with staff, management or their children.
* are aware of external mechanisms to provide feedback.

Consumers, their families, friends and carers are supported to provide feedback and make complaints. Mechanisms include feedback forms located throughout the service, a range of surveys and regular consumer meetings.

Consumers are informed of advocacy and language service when they first enter the service, through the consumer handbook and pamphlets available at reception. Staff interviewed described having Aged Right Advocacy Services (ARAS) attend the service and provide information to consumers about their rights.

The Assessment Team viewed the feedback register and sampled feedback records which showed the service was capturing and actioning compliments and complaints. Catering staff interviewed described how they action feedback in relation to food. Documentation sampled by the Assessment Team showed staff are aware of open disclosure practices.

Feedback and complaints are reviewed and used to improve the quality of care and services. A feedback register is maintained, and feedback received is collated and used to identify opportunities for improvement. Management interviewed described receiving feedback on meals and how they implemented a strategy to improve the quality of care and services for a range of consumers.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with all Requirements in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-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 Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

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

In relation to all other Requirements in this Standard, the Assessment Team found that consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. The following examples were provided by consumers during interviews with the Assessment Team:

* were complimentary about staff and described how staff are kind, caring and respectful.
* staff attend to consumers’ care and services needs and know what they are doing.
* Four consumers said staff know their needs and respect their independence.
* and felt that staff know their job role.

Staff interactions with consumers were observed by the Assessment Team to be kind, respectful and caring. The service demonstrated it has a process to recruit and train staff to ensure the workforce which is recruited has the appropriate knowledge and supports staff with resources to undertake their role.

Staff complete competency assessments and formal training when staff are initially recruited and ongoing based on their role, observations of staff practice, and feedback provided by consumer, representatives and others. In addition management interviewed described monitoring staff practice for competence through audits and reviewing incident data. The service has a training matrix which details mandatory training requirements according to job roles.

Staff practice is monitored, and ongoing training is provided to ensure staff have a contemporary knowledge base to deliver the outcomes required by the Quality Standards. Monitoring of staff practice informs staff training, with recent training provided to staff on Management of choking and Dignity of risk. The staff handbook outlines expectations for staff performance and includes information on behaviour standards, customer service and person-centred care.

The performance of each member of the workforce is undertaken on an as required basis and formally according to a set schedule. Staff interviewed were able to provide examples of current performance management issues and how management were working to address the issue.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with Requirement (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources Feedback and complaints.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-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.*

The Assessment Team were not satisfied the service demonstrated the workforce is planned to ensure the delivery and management of safe and quality care and services. Deficiencies identified by the Assessment Team related to sufficient numbers of staff with the appropriate skill mix to deliver safe and quality care and services. This was evidenced by the following.

* Observations by the Assessment Team during the Site Audit indicated insufficient staff in the memory support unit to implement recommended strategies for the management of consumers displaying behaviours of concern. This was supported through staff interviews undertaken by the Assessment Team.
* Three consumers and one representative were not satisfied with the number of staff available to provide care and services.
* Four staff interviewed indicated there are not enough staff to manage consumers with behaviours of concern in the memory support unit, provide personal care and support consumers undertaking their exercises as recommended by the Physiotherapist. Staff interviewed were able to provide examples about how insufficient staff numbers were impacting on the care and services being delivered for individual consumers.
* Rostering staff described the difficulty experienced in filling shifts and how labour hire staff providers do not always have staff available which results in shifts not always able to be filled.
* Allocation sheets from two weeks prior to the date of the Site Audits showed nine of 13 physiotherapy assist shifts were not filled and 10 of 26 coordinator and/or carer shifts were not filled. This included three care staff shifts in the memory support unit and 6 care staff shifts in two other wings.
* The staff member responsible for ensuring consumers’ religious and spiritual needs, goals and preferences are delivered is new to their role and was not adequately supported. One consumer and one representative of a consumer were not satisfied with the prevision of care and services in relation to religious and spiritual needs.
* Management said they are aware of staff shortages and are recruiting to ensure sufficient staffing to fill shifts.

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

* Review of staffing within the service.
* Commenced recruiting process with fortnightly intake of staff.
* Review staffing vacancy contingency plan.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service was not able to demonstrate 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. In particular deficits in relation to sufficiency of staffing and ensuring new staff are adequately supported to undertake their roles.

In coming to my decision, I have considered the observations made by the Assessment Team in relation to insufficiency of staffing to manage consumers displaying responsive behaviours in the Memory Support Unit. I have also considered the totality of feedback provided by consumers, representatives and staff in relation to insufficiency of staffing. Moreover, sampled staff allocation sheets further supported my view of insufficiency of staffing.

For the reasons detailed above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

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

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

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

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

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

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

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

In relation to all other Requirements in this Standard, the Assessment Team found that overall, consumers and representatives sampled considered that the organisation is well run and they can partner in improving the delivery of care and services. The following examples were provided by consumers during interviews with the Assessment Team:

* are involved in the development and evaluation of care and services and are involved in the new building project.
* have been consulted about call bell response times.

Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement through care and service review processes, meetings, surveys and consultative processes.

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

The Clinical Governance Committee oversees high-impact, high-prevalence risks relating to the care of consumers. Training on abuse and neglect is provided annually to support staff in identifying incidents of abuse and neglect. Consumers are supported to live the best life they can through the organisation’s risk management framework.

The organisation demonstrated a clinical governance framework which included a range of policies and procedures to support staff practice in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure. Clinical data is reported through a range of meetings and forums to ensure oversight over clinical care.

Based on the evidence documented above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Compliant with Requirement (3)(a), (3)(b) and (3)(e) in Standard 8 Organisational governance.

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

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

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

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

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

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

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

The Assessment Team found whilst the organisation demonstrated effective organisation wide governance systems in relation to information management, continuous improvement, financial and workforce governance, feedback and complaints, the organisation did not consistently demonstrate effective governance systems in relation to regulatory compliance. The Assessment Team were not satisfied the service demonstrated understanding and application of legislative requirements, specifically regarding mandatory reporting, in circumstances where a discretion not to report applies, serious incidents; and in relation to minimising the use of restraint. This was evidenced by the following.

In relation to reportable assaults as legislated;

* The organisation’s procedure to guide staff in relation to reporting and managing alleged reportable assault incidents had not been updated to reflect current legislative requirements.
* Care file documentation showed nine consumer-to-consumer assault incidents where discretion to not report has been used, were not recorded on a consolidated record in accordance with legislative requirements. This included strategies implemented within 24 hours for consumers who had a diagnosed cognitive impairment prior to the incident and the identification of both the alleged victim and alleged perpetrators documented on the consolidated record.
* Management advised they were not aware the incidents had not been documented in the mandatory reporting register and that behaviour strategies had not been reviewed in accordance with legislative requirements. They advised further education would be provided in relation to mandatory reporting.

In relation to requirements to report serious incidents;

* Progress notes show for one consumer one week prior to the Site Audit, staff documented unexplained bruising on a consumer’s forearm. The Assessment Team noted the incident form had not been completed and the incident was not on the service’s register or incident reporting system.

In relation to restrictive practices;

* The organisation does not consistently document alternatives initiated prior to chemical restraint being used and did not demonstrate the restraint was used as last resort for four consumers in accordance with legislative requirements.
* Three consumers’ care files showed records of staff administering medication in the form of chemical restraint, however, evidence the representative was informed or provided consent were not recorded.

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

* Review previous incidents and update the service’s Mandatory Reporting Register.
* Provide education to staff on the Serious Incident Response Scheme.
* Develop a Serious Incident Response Scheme Register.
* Review internal policies and procedure in relation to restraints, provide education to staff on restraint use and updated relevant consent forms informing consumers and representatives of medication usage in the form of chemical restraint.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service was not able to demonstrate effective organisation wide governance systems relating to adherence with legislative requirements relating to identification and management of reportable assaults, restrictive practieces and incident management and prevention.

In coming to my decision, I have considered the service’s policies and procedures to guide staff in relation to managing reportable assaults as legislated and noted relevant policies and procedures have not been updated to include the current legislative requirements at the time of the Site Audit. In addition, the service did not manage nine consumer-to-consumer assault incidents in accordance with legislative requirements. Moreover, evidence identified by the Assessment Team in relation to chemical restraints indicates the service is not aware of its legislated responsibilities to trial alternative strategies and ensure consumers who are administered medication in the form of chemical restraint have relevant consent documented in accordance with relevant legislation. Additionally, the service did not ensure an incident where a consumer sustained an unexplained bruise had relevant information recorded on the service’s incident management system in accordance with legislative requirements.

For the reasons detailed above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team found whilst the service has an organisational risk management framework, it was not always effective or consistently implemented to ensure risks to consumers are identified, documented, managed and monitored in relation to behaviour of concern incidents, serious incidents and managing the risk for consumers who are prescribed and administered medication in the form of chemical restraint. This was evidenced by the following;

* The organisation’s procedures guides staff to record all consumer incidents on the service’s incident reporting system.
* Four behavioural incidents involving one consumer and two incidents involving another consumer were not recorded on the incident management system and relevant evaluations and investigations were not undertaken by staff from the service.
* The organisation’s procedure guides staff on reporting of serious incidents, however one incident involving a consumer with an unexplained bruise on their forearm did not result in the incident being recorded on the service’s incident management system.
* Management advised staff do not always understand the importance of incident reporting documentation and say they don’t have time. Management said staff have been provided education on documentation, mandatory reporting and the Serious Incident Response Scheme (SIRS), however, further education is required.
* As demonstrated in Standard 3 requirement (3)(a), the organisation did not demonstrate effective clinical risk management for three consumer displaying responsive behaviours. This included effective identification of triggers to support management and appropriate use of medication in the form of chemical restraint. Although these consumers were identified on the risk register for ongoing responsive behavioural incidents, these were not consistently discussed at the meeting and strategies to manage consumers’ behaviours were not consistently implemented to inform care plan updates and timely referrals to external services.

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

* Provide education to staff on the Serious Incident Response Scheme and develop a Serious Incident Response Scheme Register.
* Review internal policies and procedure in relation to restraints, provide education to staff on restraint use and updated relevant consent forms informing consumers and representatives of medication usage in the form of chemical restraint.
* Providing education and training to staff to ensure best practice in the prevention and management of challenging behaviours and updating care planning and assessment documentation in relation to managing behaviours of concern.

I acknowledge the provider’s response and the actions taken in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service was not able to demonstrate effective risk management systems and practices, including but not limited to managing and preventing incidents.

In coming to my decision, I have noted the failure in the service to use their incident management system to record and subsequently evaluate relevant incidents on the service’s incident management system as identified by the Assessment Team and in line with the service’s policies and procedures. In addition, I have accepted the response provided to the Assessment Team from management in that staff do not always understand the importance of incident reporting and further education is required.

I recognise the service has a register where consumers who have identified high-impact and high-prevalence risks, have these risks recorded and discussed and a regular meeting. However, this risk management process was not effective for three consumers who had ongoing responsive behaviours documented and strategies were not always identified and implemented following the meeting.

For the reasons detailed above, I find Barossa Hills Fleurieu Local Health Network Incorporated, in relation to Strathalbyn & District Aged Care Facility, to be Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

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

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

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

# Areas for improvement

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

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

* Review processes for the assessmesment and management of consumers who display behaviours of concern.
* Review processes for the administration of medication in the form of chemical restraint to ensure compliance with relevant legislative requirements.

**Standard 4 Requirement (3)(b)**

* Investigate and implement alternative service delivery options to ensure consumers’ spiritual needs goals and preferences are identified and addressed.

**Standard 7 Requirement (3)(a)**

* Analyse the staff roster to identify opportunities for improvement to care and service delivery.
* Ensure new staff are adequately supported in their roles.

**Standard 8 Requirements 8(c) and 8(d)**

* Review risk management systems to ensure incidents and high-impact and high-prevalence risks are effectively identified, managed and monitored.
* Review processes to ensure incidents are captured and evaluated to ensure opportunities for improvement are identified. In addition, review incident management system to ensure incidents are captured and managed in line with legislative requirements.
* Ensure staff are aware of their responsibilities in relation to Incident Management and undertaking relevant reporting.