Performance

Report

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| Name of service: | Fullarton Lutheran Homes |
| Service address: | 14 Frew Street FULLARTON SA 5063 |
| Commission ID: | 6047 |
| Approved provider: | Lutheran Homes Group Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 February 2023 |
| Performance report date: | 15 March 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Fullarton Lutheran Homes (**the service**) has been prepared by K. Richards delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

# Material relied on

The following information has been considered in preparing the performance report:

* The Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others.
* The Performance Report dated 8 September 2022 in relation to the Site Audit conducted from 11 July 2022 to 14 July 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirements (3)(d) and (3)(f) were found non-compliant following a Site Audit undertaken from 11 July 2022 to 14 July 2022.

* Under Requirement (3)(d), the service was unable to demonstrate each consumer was supported to take risks to enable them to live the best life they could, specifically in relation to consumers leaving the service independently, and who smoke and/or drink alcohol.
* Under Requirement (3)(f), the service did not demonstrate consumers’ privacy was respected and personal information kept confidential, with staff using personal phones and emails to send photographs of wounds for uploading, and observations of poor staff practice in relation to consumer privacy.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Review and update of dignity of risk policy and procedures to appropriately support consumers taking risks. Subsequent staff training, information for consumers, and review of consumer risk assessments was also undertaken.
* Training was provided to staff in relation to maintaining consumer privacy when providing care and services, and ensuring clinical information is not recorded or stored on personal devices. Written instruction was also provided to all staff in relation to ceasing to take photographs of wounds on mobile phones, and ensuring areas with stored consumer information are secured.

The Assessment Team found the service demonstrated each consumer is supported to take risks to enable them to live the best life they can, and privacy is respected and personal information kept confidential.

Consumers said risks associated with activities of choice were discussed with them, and clinical staff put strategies in place to minimise risk. Risk assessment forms captured risks in line with consumer feedback, and staff demonstrated understanding of risk minimisation strategies and review processes in line with care planning for sampled consumers.

Clinical staff confirmed wounds were photographed using service issued electronic devices, such as the mobile phone or iPad, and the process followed to upload them into consumer profiles was reflective of work instructions, policies, and procedures. Nurses’ stations and kitchenette areas were secured, and there was no consumer information on display.

For the reasons detailed above, I find Requirements (3)(d) and (3)(f) in Standard 1 Consumer dignity and choice Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |
| Requirement 2(3)(b) | 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. | Compliant |
| Requirement 2(3)(c) | 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. | Compliant |
| Requirement 2(3)(e) | 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. | Compliant |

Findings

Requirements (3)(a), (3)(b), (3)(c), and (3)(e) were found non-compliant following a Site Audit undertaken from 11 July 2022 to 14 July 2022.

* Under Requirement (3)(a), the service could not demonstrate comprehensive assessment being undertaken for sampled consumers to inform safe and effective care and services.
* Under Requirement (3)(b), assessment and planning did not capture planning relating to end of life or advance care directives.
* Under Requirement (3)(c), the service did not demonstrate assessment and planning was based on ongoing partnership with the consumer or others they wished to be involved, such as representatives.
* Under Requirement (3)(e), care and services were not being reviewed regularly or following incidents, particularly in relation to falls, pain monitoring, or deterioration.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewing of policies, procedures, and work instructions relating to assessment planning for clinical care, including pain, diabetes, oxygen therapy, behaviours of concern, and end of life directives with subsequent staff training and reviewing and updating of all care plans.
* Training for staff on care planning being undertaken in partnership with the consumer or those they wish to be involved, and ensuring a copy of the care plan is offered. Information on this was also shared within Resident Meetings and through flyers.
* Training for clinical staff on monitoring of progress notes for incidents or changes to trigger care review.
* Review and changes to the electronic care system templates in line with amendments to policies and processes, with changes to assessments and planning copied automatically into progress notes.
* Undertaking of a consumer satisfaction survey in January 2023, although the results had not yet been evaluated at time of the Assessment Contact.
* Monitoring of compliance with scheduled reviews, with reporting to organisational management.

The Assessment Team found assessment and planning includes consideration of risk to inform safe and effective care, addresses current needs, goals and preferences, including advance care and end of life planning, is undertaken in partnership with the consumer or those they wish to involve, and care and services are reviewed regularly and when circumstances change or when impacted by incidents.

Representatives confirmed care planning identified individual risks for consumers, and were used to inform personalised care and services. Staff demonstrated familiarity with assessment processes and confirmed care plans and communications contained sufficient information to guide care. Sampled care plans included personalised behaviour support plans with guidance on consumer experience and background, triggers, and personalised interventions.

Consumers and representatives confirmed assessment and planning includes and addresses consumers’ needs, goals, and preferences, capturing advance care directives or end of life planning if they consumer wished to discuss it. Staff were aware of how to access end of life wishes, and reported the Clinical Nurse was responsible for assessment during admission. Management is monitoring review and completion of advance care directives. Information within sampled care plans was personalised, and captured any personalised wishes for end of life care.

Most consumers and representatives interviewed said they were involved in assessment of planning of consumers’ care, and all said they felt staff were aware of their needs. Progress notes demonstrated discussion and consultation with consumers and representatives on entry and on an ongoing basis, with involvement of other health practitioners and providers.

Consumers and representatives said they were consulted on a frequent basis in relation to care and services, and advised promptly of incidents or changes. Care files demonstrated evaluation of assessment and consideration of new strategies following incidents. Progress notes and incidents are reviewed daily to promptly identify when review or reassessment is required, with regular monthly and six monthly embedded review processes.

For the reasons detailed above, I find Requirements (3)(a), (3)(b), (3)(c), and (3)(e) in Standard 2 Ongoing assessment and planning with consumers Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 11 July 2022 to 14 July 2022.

* Under Requirement (3)(b), the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to falls, and skin and wound care.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Review and updates of assessment and planning policies and procedures for high incident and/or prevalence risks, specifically skin integrity, pressure injuries, and falls. Subsequent training for clinical staff on these matters included focus on documentation requirements and monitoring of wounds.
* Ongoing internal audits of wound charting, with monthly review by the Clinical Nurse for additional oversight of wound healing and referral requirements.

The Assessment Team found the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer.

Overall, consumers and representatives were satisfied the service was aware of consumer risks with effective management. Staff were knowledgeable about consumer risks and mitigation strategies. Consumers’ risks were noted in the care plan, and handover included reference to short term risks and/or charting and assessment requirements. Consumer risks are discussed during regular Clinical Health and Well-being meetings. A new exercise program is being introduced following identification of falls being a high risk for the current consumer cohort. Whilst one consumer’s care file did not demonstrate non-pharmacological strategies used prior to use of chemical restraint were in line with those within the behaviour support plan, staff were able to demonstrate familiarity with documented successful strategies. The service was able to demonstrate ongoing monitoring and review of chemical restraint was used to reduce or discontinue its use.

For the reasons detailed above, I find Requirement (3)(b) in Standard 3 Personal care and clinical care Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | 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. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirements (3)(c) and (3)(f) were found non-compliant following a Site Audit undertaken from 11 July 2022 to 14 July 2022.

* Under Requirement (3)(c), the service was unable to demonstrate services and supports for daily living assisted each consumer to do things of interest to them, with feedback that scheduled activities were either not of interest, not inclusive for consumer needs, or staff not supporting consumer access.
* Under Requirement (3)(f), the service did not demonstrate meals were varied and of suitable quality, with dissatisfaction of the flavour, variety and quality, including temperature and incorrect cooking technique.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* A lifestyle focus group was implemented to gain input from consumers about improving scheduled activities, with continued feedback sought from Resident Meetings.
* A dedicated lifestyle program was developed for the memory support unit, and Montessori activity boxes implemented for individual use.
* Creation of a care evaluation template to assist staff reviewing lifestyle assessments and care plans. All care plans were reviewed to ensure current consumer preferences, interests, and goals were captured, and cultural and spiritual assessments completed.
* Catering menus have been reviewed and redeveloped with input from consumers, representatives and a Dietitian. A monthly food focus group has been established for feedback and suggestions regarding meals, catering services, and the dining experience.
* The new Hotel Services Manager has introduced surveys to monitor the food quality and dining experience, attends Resident and family meetings to provide updates and gather feedback. Personalised menus are available, if required, allowing consumers to identify meals they like and dislike and selecting substitute meals.
* Food orders were reviewed and the supplier changed. New hotboxes have been introduced to ensure meals are kept warm. A new Chef commenced in January 2023.

The Assessment Team found the service is assisting consumers to participate in community, have personal and social relationships, and do things of interest to them, and meals provided were varied and of a suitable quality and quantity.

All consumers and representatives were satisfied with support provided to do things of interest and maintain meaningful relationships. Representatives said the lifestyle program in the memory support unit had been greatly improved with activities suitable for consumers, their interests, and physical and cognitive abilities. Staff were able to identify activity preferences and how they provided support to consumers to maintain relationships or participate in activities. Lifestyle described activities are scheduled over seven days until 7:30pm, and personalised support was provided to consumers on an individual basis too. Although it was identified not all interests or current activity preferences were captured in care planning for sampled consumers, overall care planning documentation included sufficient information about consumer interests, preferences, and history to guide staff.

Consumers and representatives said they were happy with meals provided, with some consumers saying food improved following the introduction of new menus late in 2022. Staff said they can see improvements in quality of meals, but alternate meals are available if consumers are not happy. The feedback log includes compliments in relation to meals, and shows consumer complaints have been addressed through provision of tailored menus or meals.

For the reasons detailed above, I find Requirements (3)(c) and (3)(f) in Standard 4 Services and supports for daily living Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | 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. | Compliant |

Findings

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 11 July 2022 to 14 July 2022.

* Under Requirement (3)(e) the service did not demonstrate an effective clinical governance framework, with deficits in oversight of assessment and management of clinical care.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Appointment of an Infection Control Lead for the organisation, and General Manager for the Quality team to undertake increased monitoring of clinical care and indicators.
* Improvements were made to the clinical handover, introducing daily communication of clinical priorities, informed by progress note reviews, to identify issues and priorities for the day.
* A review of policies and procedures with identified deficiencies, and undertaking of audits on both site and organisational level with benchmarking completed by the Quality team.

The Assessment Team found the service demonstrated an effective clinical governance framework which includes systems to review and analyse clinical indicators and incidents, and has reporting mechanisms to ensure effective oversight.

The clinical governance framework includes policies and procedures to guide staff in practice, and systems to identify areas of continuous improvement. The use of restrictive practices is monitored, with informed consent sought and behaviour support plans completed. The service has systems for preventing, managing and controlling infections and antimicrobial resistance which is monitored and reported through clinical indicator data. There are systems to support communication with consumers about incidents and complaints with prompts to demonstrate how open disclosure was practiced. The Assessment Team raised concerns in relation to staff familiarity with restrictive practice terminology and processes, however, as the service has implemented policies and procedures and planning in line with legislative requirements, I consider this relates more to Standard 7 Requirement (3)(d) which was not assessed at the Assessment Contact. Meeting minutes show the organisation monitors and analyses clinical data and incidents and benchmarks the data against other services within the organisation to identify trends and areas for improvement.

For the reasons outlined above, I find Requirement (3)(e) in Standard 8 Organisational governance Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)