Helping Hand Aged Care - Lealholme Port Pirie

Performance Report

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**Commission ID:** 6173

**Provider name:** Helping Hand Aged Care Inc

**Assessment Contact - Site date:** 23 February 2022 to 24 February 2022

**Date of Performance Report:** 26 April 2022

# Performance report prepared by

Janine Renna, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |

# Detailed assessment

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

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

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

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

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team has recommended the service does not meet Requirement (3)(b) and meets Requirement (3)(d) in Standard 3. The Assessment Team found the service demonstrated deterioration or change of a consumer’s mental health, cognitive or physical function was recognised and responded to in a timely manner. However, the Assessment Team was not satisfied high impact or high prevalence risks were effectively managed.

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

### Assessment of Standard 3 Requirements

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

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

The Assessment Team was not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to wounds, diabetes and chemical restraint. The Assessment Team provided the following evidence relevant to my finding:

Wound management

* In relation to two consumers’ wounds:
  + Wound charting demonstrated inconsistency or absences of measurements, and photographs were not uploaded weekly in line with the organisation’s wound policy.
  + Photographs were taken from differing angles, with the tape measure at times across the length of the wound, and at other times across the width.
  + In relation to one of the two sampled consumers, following identification of their pressure injury, a skin reassessment and care plan review was not undertaken, with the most recent skin assessment undertaken six months prior.
  + Photographs demonstrated at the time of the Assessment Contact, one of the two sampled consumers’ wounds had healed.
  + Management acknowledged it is difficult to determine whether there was improvement or deterioration within the wound based on the wound charting sampled by the Assessment Team.
* Staff could describe the requirements of wound care and documentation in line with the organisation’s procedures.
* Management reported the service’s wound documentation system had recently changed and staff may still be getting familiar with it. Documentation showed emails were sent to staff on five occasions since August 2021 regarding implementation of a new wound documentation system.

Diabetes management

* Consumer A:
  + Documentation showed one consumer’s care plan was not updated to reflect a reduction in blood glucose level (BGL) monitoring frequency, as requested by a medical officer.
  + Charting and progress notes for a six-day sampled period does not indicate sugary drinks were provided to the consumer on the four occasions their BGLs were outside the specified range, in line with medical officer directives.

Management reported that three of the four occasions where the consumer’s BGLs were out of range had been recorded by one staff who was relatively new.

* Consumer B:
  + Documentation showed the consumer’s diabetic monitoring and management was undertaken in line with their care plan, and actions taken for reportable readings were included in charting and progress notes.

Chemical restraint

* The service did not identify one consumer was subject to chemical restraint, despite being administered as required psychotropic medication for the management of agitation.
* The Assessment Team sampled three consumers which were identified by the service as being subject to chemical restraint:
  + One consumer’s Behaviour support plan did not identify risks associated with sedation, including increased falls, choking and weight loss.
  + One consumer’s Behaviour support plan lacked personalised information in the form of triggers.
  + Two consumers’ Behaviour support plans did not include personalised strategies that had been successful or unsuccessful in management of their behaviours.
  + Recommendations made by Dementia Support Australia had not been implemented or incorporated into one consumer’s care plan, despite having been received one month prior to the Assessment Contact.
  + Care planning documentation was not updated following three panic attacks experienced by one consumer.

The provider did not disagree with all the Assessment Team’s findings, however, maintains that the deficiencies identified do not indicate ineffective management of high impact or high prevalence risks associated with the care of each consumer. The provider’s response includes the following information and evidence to refute the Assessment Team’s assertions:

* Wound charts for both consumers identified by the Assessment Team to support that inconsistent charting of wound dimensions has stemmed from changes in the clinical system that mandates wound dimension fields.
  + Wound measurements are undertaken weekly by a registered nurse, however, when an enrolled nurse completes a dressing they need to enter a measurement to save the chart. This issue had been self-identified and fields in the wound chart have been changed to accommodate free text, so staff can document that measurements were not undertaken.
* In relation to Consumer A, the error occurred as their BGL chart had been set up with a reportable range of 4mmol/L to 15mmol/L, rather than 6mmol/L to 15mmol/L as per medical officer directives. On all four occasions, the consumer’s BGLs were just below 6mmol/L and there were no adverse impacts.
* A Behaviour support plan for one consumer to demonstrate that strategies are included to guide staff when they refuse care. The Behaviour support plan was not dated to demonstrate it was in place at the time of the Assessment Contact.
* A care plan update was not required for the consumer who experiences panic attacks, as it was not a new behaviour or occurrence.

The response also includes evidence of actions taken to address deficits identified by the Assessment Team, which include, but are not limited to:

* Scheduling training for staff in relation to wound photographing, diabetic management, restrictive practices and Behaviour support plans;
* A new BGL chart has been set up for Consumer A to reflect the correct reportable range; and
* One consumer who was prescribed psychotropic medication for agitation has been reviewed by a medical officer and appropriate consent obtained.

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

In relation to wound management, while evidence indicates areas for improvement in relation to wound documentation, and assessment and planning processes, there was no evidence the wounds were not being managed. I find this evidence is more aligned with Requirement (3)(a) in this Standard and Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers, which were not assessed at the Assessment Contact.

In relation to diabetes management, the core deficiency stemmed from the BGL chart, including an incorrect reportable range and the care plan not being updated to include a change in medical officer directives. The evidence presented by the Assessment Team does not indicate any adverse outcomes for the consumer, nor does it indicate that high impact or high prevalence risks associated with the care of the consumer were not effectively managed. I find the evidence is more aligned with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers, which was not assessed at the Assessment Contact.

In relation to chemical restraint, information in the Assessment Team’s report does not indicate ineffective management of consumers’ behaviours. While the Assessment Team’s report includes evidence that Behaviour support plans lacked personalised information and care plans were not updated to include recommendations from Dementia Support Australia, I find the evidence is more aligned with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers and Requirement (3)(e) in Standard 8 Organisational governance, which were not assessed at the Assessment Contact.

Information included in the Assessment Team’s report also demonstrates the service did not identify that one consumer prescribed psychotropic medication for the purposes of agitation was being chemically restrained. I find this deficiency relates to Requirement (3)(e) in Standard 8 Organisational governance, which was not assessed at the Assessment Contact.

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

### 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.*

The Assessment Team was satisfied the service demonstrated 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. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives reported appropriate and prompt action had been taken in response to deterioration in health, including assessments, observations, medical reviews and hospital transfers.
* Staff were familiar with sampled consumers’ care needs and could describe actions they had taken in response to changes in consumers’ health and well-being.
* Interviews with staff and documentation supported that care and services had been changed in response to one consumer’s deterioration of physical function and one consumer’s change in mental health.
* Documentation showed a range of monitoring tools and assessments are completed on an ongoing basis to identify and evaluate changes to consumers’ health, condition and abilities.
* The service has processes in place to identify deterioration or a change in consumers’ health and well-being, including Resident of the day, High risk residents register and High risk residents’ meetings.
* The organisation has policies and procedures to guide staff on identification and management of deterioration or changes in condition.

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

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

# STANDARD 7 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 Assessment Team assessed Requirement (3)(a) in Standard 7 Human resources. All other Requirements in this Standard were not assessed; therefore, an overall rating of the Standard is not provided.

The Assessment Team has recommended the service meets Requirement (3)(a) in Standard 7. The Assessment Team was satisfied the service demonstrated 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.

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

## 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.*

The Assessment Team was satisfied the service demonstrated 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 provided the following evidence relevant to my finding:

* Consumers and representatives reported staff are responsive to consumers’ needs and attend to call bells in a timely manner, and there are enough numbers of both male and female staff to meet consumers’ preferences.
* Staff considered they have enough time to undertake their duties and can spend quality time with consumers.
* Management reported staffing numbers are rostered for 104 consumers despite having only 75 consumers residing at the service.
* Rosters for a sampled period demonstrated all shifts were covered and feedback systems did not reflect any concerns being raised by consumers or staff regarding staffing numbers.
* Staff were observed attending to call bell activations in a timely manner and did not appear rushed when interacting with consumers.

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

Based on the information summarised above, I find the service compliant with Requirement (3)(a) in Standard 7 Human resources.

# 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 Assessment Team assessed Requirement (3)(d) in Standard 8 Organisational governance. All other Requirements in this Standard were not assessed at the Assessment Contact.

The Assessment Team has recommended the service does not meet Requirement (3)(d) in Standard 8. The Assessment Team was not satisfied the service demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and managing and preventing incidents.

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

## Assessment of Standard 8 Requirements

### 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 was not satisfied the service demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and managing and preventing incidents. The Assessment Team provided the following evidence relevant to my finding:

Documentation and interviews with management demonstrate monitoring systems relating to diabetes and wound management are not always effectively identified or managed. For example:

* Clinical audit undertaken regarding diabetes management and monitoring, and skin integrity and wound management showed a result of 65.33% and 42.8% compliance with the service’s audit criteria respectively.
* Management were unable to provide analysis or actions to be taken to rectify identified deficits and none were included in the service’s Plan for continuous improvement.

Documentation and interviews with staff showed the organisation’s risk management systems and practices did not ensure reporting was undertaken in accordance with legislative requirements. For example:

* One incident of alleged inappropriate behaviour by one staff towards one consumer was not included in the service’s Serious Incident Response Scheme (SIRS) register or in other incident documentation.
  + Following the incident, one staff reported they completed an incident form and placed a copy in the incident folder in line with the organisation’s processes. The staff member said it appeared no action had been taken so approximately 13 days after the incident, they submitted the incident form to the organisation’s Human resources department.
  + The Assessment Team noted this incident was not included in the SIRS register or in other incident documentation provided.
  + At the time of the Assessment Contact, the incident had not been reported as required under the SIRS, despite having occurred almost one month prior.
* Documentation showed four Priority 1 incidents were not reported within 24-hours as required under the SIRS.

Documentation and interviews with staff and management demonstrated the organisation’s systems and practices did not ensure regulatory obligations were met as required under the *Quality of Care Principles 2014*. For example:

* The service did not respond to an incident by assessing the support and assistance required to ensure the safety, health and well-being of persons affected by the incident, and provide that support to those persons.
  + In relation to one of four incidents sampled, evidence indicated the two persons involved in the allegations were separated for one evening. However, there was no evidence demonstrating that actions had been taken to ensure the safety, health or well-being of the consumer, and other consumers at the service, from the day after the allegations until the staff member’s suspension, which occurred 15 days after the incident.
  + In relation to all four incidents sampled, management reported lifestyle staff were instructed to provide emotional support to the four affected consumers on 15 days after the first allegation. Staff interviews, and lifestyle activity records contradict this statement.
* The service did not assess how to appropriately involve each person affected by the incident, or a representative of that person, in the management and resolution of the incident, and involve each person in that way, and use an open disclosure process.
  + Documentation showed management held a meeting with three consumers and one representative, relating to alleged inappropriate behaviour displayed by one staff member.
  + The consumers could not recall being subject to inappropriate behaviour, however, two of the three interviewed have moderate to severe cognitive decline.

Management confirmed the representatives of these two consumers with cognitive decline have not been contacted regarding these allegations.

* + Documentation and feedback from the representative demonstrate open disclosure of the specific allegations respective of the consumer did not occur.

Management said the investigation is still pending and open disclosure would be made if allegations were found to be proven.

* The service did not report the incident to police within 24 hours of becoming aware of the incident.
  + Management reported none of the four alleged incidents of inappropriate behaviour had been reported to SA Police at the time of the Assessment Contact.

The provider did not disagree with all the Assessment Team’s findings, however, maintains that the organisation’s risk management systems are robust and investigations into allegations of inappropriate behaviour were actioned immediately and appropriately. The provider’s response states the following:

* The service was unaware of the allegations of inappropriate behaviour until contacted by the Aged Care Quality and Safety Commission, 13 days after the first alleged incident occurred. The service subsequently confirmed that three staff had submitted separate reports of alleged inappropriate behaviour by one staff member and the staff member was immediately stood down pending investigation to ensure the safety of consumers.
* The incident form placed by one staff in the incident folder was never submitted to management and after reviewing the copy provided to the Assessment Team, it is noted that the form names a different consumer, it is not version controlled and evidence from various sources disproves the staff’s accounts of what had occurred.
* Deficiencies identified by the Assessment Team in relation to open disclosure do not indicate systemic issues, rather a staff performance issue.
* The service’s decision not to involve family in the incident management process was appropriate due to the sensitive nature of the allegations.
* The service’s audit results are discussed at the organisation’s Quality Committee and Audit subcommittee. An Agenda and Terms of reference were provided in support of this statement.

I acknowledge the provider’s response and associated information provided, however, in coming to my finding, I have relied upon interviews with staff and management, and documentary evidence which demonstrated at the time of the Assessment Contact, the organisation’s risk management systems and practices were not effective in identifying abuse and neglect and managing and preventing incidents.

I have considered that systems and processes were not effective in identifying alleged inappropriate behaviour by one staff member towards four consumers. The service was not aware of these incidents until contacted by the Aged Care Quality and Safety Commission, despite them having been reported on at least one occasion at that stage.

The delay in awareness of the incident resulted in no actions being taken to ensure the safety, health and well-being of persons affected, and the consumers continued to reside in an environment where the perpetrator worked for 15 days after the first incident, until they were stood down.

I have considered that systems and processes were not effective in ensuring regulatory obligations under the SIRS and *Quality of Care Principles 2014* were met, as incidents were not reported within legislated timeframes, open disclosure processes were not followed, and the incident was not reported to SA Police.

In relation to the organisation’s systems and processes to manage high impact or high prevalence risk, I find that it is not proportionate to suggest they are ineffective based solely on the deficiencies identified. I have placed weight on evidence included in the provider’s response which demonstrates audit results are analysed and actions are discussed at the service’s Quality committee and Audit subcommittee.

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

# Areas for improvement

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

Standard 8 Requirement (3)(d)

* Review the organisation’s risk management systems in relation to identifying and responding to abuse and neglect of consumers and managing and preventing incidents.
* Ensure staff understand the organisation’s policies and procedures in relation to incident reporting.
* Monitor staff compliance with the organisation’s policies and procedures in relation to incident reporting.