Port Pirie Regional Health Service - Hammill House

Performance Report

The Terrace
PORT PIRIE SA 5540
Phone number: 08 8638 4696 or 08 8638 4500

**Commission ID:** 6302

**Provider name:** Yorke and Northern Local Health Network Incorporated

**Site Audit date:** 17 May 2022 to 19 May 2022

**Date of Performance Report:** 14 July 2022

# Performance report prepared by

Therese Wilson, 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

|  |  |
| --- | --- |
| **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** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Non-compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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 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 17 June 2022.

# STANDARD 1 COMPLIANTConsumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of six specific requirements have been assessed as Compliant.

The Assessment Team found overall, sampled consumers interviewed considered 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:

* Staff are respectful of consumers’ background, ethnicity, culture and what is important to them.
* Consumers and representatives said they felt comfortable communicating their decisions with the service and felt those decisions were respected and supported.
* Consumers can exercise choice and independence regarding the care and services delivered and who should be included in making those decisions.
* Consumers reported being supported to make connections with others and maintain relationships of choice.
* Consumers sampled confirmed they are supported to take risks, with mitigating strategies implemented to support them in doing so.

The service demonstrated consumers’ care and services needs are identified through undertaking assessments with consumers and representatives to capture what culturally safe care looks like for consumers. There are policies and procedures in place to guide staff in identifying risks and supporting consumer choices that enable them to live the best life they can.

Staff were observed to interact with consumers respectfully and could readily identify consumer’s individual preferences and interests. Staff could provide meaningful examples of how they help consumers make choices, including by giving consumers clear and accurate information and options to inform their choice.

Staff gave examples of how they maintain the privacy of consumers. They could demonstrate their understanding that consumers receiving personal care can feel vulnerable and what they do to ensure consumers are made to feel respected and comfortable. The organisation demonstrated how electronic and manual filing systems support the protection of confidential information including consumer information, consistent with documented policies and procedures.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, 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 confirmed they feel like partners in the ongoing assessment and planning of their care and services that helps them get the care and services the consumers need for their health and well-being. The following examples were provided by consumers during interviews with the Assessment Team:

* Consumers and representatives confirmed they have been involved in, or informed of, assessment and planning and the care plan review process.
* Consumers’ needs, goals and preferences had been recognised by the service and influenced the delivery of care.
* Consumers’ representatives confirmed they are involved in the care planning process or are contacted by the clinical staff or management if there are any changes with their consumer’s circumstances.
* Consumers confirmed the service had discussed their care plan with them or their representatives at care plan reviews and were satisfied they are informed of any changes to their care or services.

Care files sampled confirmed a range of assessments relating to both clinical and lifestyle aspects of care are completed on entry, every three months and where changes to consumers’ health and well-being are identified. Information gathered from assessment processes and consultation with consumers and/or representatives is used to develop individualised care plans which are readily available to staff.

Staff described how Medical Officers and Allied Health professionals were involved in planning consumers’ care, and changes to care plans and management strategies were noted by the Assessment Team to have been initiated in response to Medical Officer and/or Allied Health directives and recommendations.

The organisation demonstrated policies and procedures guide staff practice and monitoring processes including 24-hour progress note reviews, to ensure care plans and assessments are reflective of consumer's needs, goals and preferences and completed correctly.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, 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-COMPLIANTPersonal 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 have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) in this Standard as not met. The Assessment Team found the service was unable to demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs and optimises their health and well-being. 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 findings in the specific Requirements below.

In relation to Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, the Assessment Team found overall, sampled consumers confirm staff they have access to a medical officer and other health professionals when they need it. Representatives confirmed they are informed of when incidents, including falls occur and are involved in making decisions about consumers’ clinical care.

The service has effective processes to manage high impact or high prevalence risks associated with the care of each consumer which includes weight loss, falls, and complex needs management. Clinical and care staff demonstrated knowledge of consumer’s personal and clinical care needs and individualised strategies for managing high impact or high prevalence risks.

Deterioration of consumers’ cognitive or physical function, capacity or condition is recognised and generally responded to in a timely manner by registered staff and referral to medical officer or allied health specialists occur appropriately. Care planning documentation demonstrates a range of tools used to assess and evaluate consumers’ changing needs, and staff demonstrated knowledge of the processes to escalate changes in consumers’ needs.

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

Staff demonstrated understanding of infection control and antimicrobial stewardship principles. Policies and procedures are in place to guide staff in the provision of care relating to personal and clinical care.

Based on the Assessment Team’s report and the Approved Provider’s response I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, 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 found the service was unable to demonstrate each consumer receives safe and effective personal care or clinical care. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumer A reported dissatisfaction with how staff assist them with personal hygiene and medication management. The consumer advised they reported to staff their preferences in relation to times and frequency of one of their medications. However, this was not followed through and staff continued administering the medication which the consumer denied taking. In addition, Consumer A reported dissatisfaction with timeliness and appropriateness of clinical staff actions in response to their concerns about feeling unwell for a few days. Consumer A advised they ended up in hospital where they were diagnosed with urosepsis.
* The Assessment Team found errors in prescription of two medications for Consumer A which were rectified by the service during the Site Audit. There was inconsistency in how staff completed fluid intake charts for monitoring Consumer A’s daily fluid intake does not exceed the restriction requirement of 2 Litres a day in line with their care plan.
* Consumer B was transferred to bed after being found on the floor without being assessed by appropriately qualified staff that it was safe to do which is not in line with the organisation’s policies and procedures on post fall management. In addition, initial neurological and vital signs observations were not carried out on initial assessment by registered staff in line with the service’s procedure until after 5 hours following the fall.
* Consumer C experienced deterioration and their pain-relieving medications were reviewed and doses adjusted. Pain charting was commenced. However, the Assessment Team found pain and behaviour charting were not completed accurately and consistently to effectively monitor pain so that effective interventions based on severity of pain levels could be implemented. Management agreed the consumer’s pain and behaviour charting had not been consistently carried out and said they were aware of deficits in pain and behaviour charting, and this had been highlighted on the Plan for Continuous Improvement.
* The Consumer C’s representative said they were informed by the service that a new medication was commenced in response to increased pain. However, they were unsure if it was effective as they can only judge by the consumer’s appearance as the consumer significantly deteriorated over the previous 2 weeks and could not effectively report their pain.

The Approved Provider submitted a response to the Assessment Team’s report, and while the Approved Provider acknowledges the gaps identified in the report, it does not agree with all the findings reported by the Assessment Team. The Approved Provider has commenced an action plan to address the gaps identified by the Assessment Team and have provided further information in relation to Consumer’s A, B and C. This information and improvement actions include, but are not limited to:

* The Approved Provider acknowledges improvements are required in relation to accuracy and consistency of completion of behaviour and pain evaluation documentation and this is being addressed through provision of training to staff and introduction of a new best practice pain assessment tool which is expected to be implemented within 6 months.
* In relation to medication prescription errors for Consumer A, the Approved Provider asserts the incident reports had been completed prior to the Site Audit and the remedial actions had been discussed with the Assessment Team which included involving a Medical Officer who prescribed medications and a pharmacist who dispensed medications, to address their practices and processes to prevent recurrence. Additional checking processes before receipt of all not packed pharmaceutical deliveries had been implemented and requires co-signing with the pharmacist/pharmacy assistant with the electronic order form accompanying the delivery to validate correct prescription.
* In relation to Consumer A, the Approved Provider asserts that Consumer A’s fluid intake was meeting the daily fluid restriction requirement of 2 Litres through provision of catering service. In addition, Consumer A does not have a cognitive impairment, is fully aware of their fluid restriction requirement, can self-manage fluid intake and report it to staff. The Approved Provider expressed their commitment to explore alternative more efficient fluid management monitoring process acknowledging deficiencies in staff compliance with completing fluid balance charting.
* In relation to Consumer B, the Approved Provider asserts the incident where a consumer was transferred to bed without being assessed by a nurse for injuries, was an isolated incident which was managed through the incident management system and the staff members involved were interviewed and reminded of their responsibility in adhering to falls protocol and escalation of care.
* The Approved Provider reports the falls management protocol was under review at the time of the Site Audit and includes a draft of the new proposed protocol to provide clear step by step instructions to direct staff in its response. The Approved Provider states education in the new protocol will occur with all care and clinical staff once the new protocol has been endorsed by relevant parties.

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

I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate they provided clinical care that is safe and effective, is tailored to the consumer needs and is provided in line with the organisation’s protocols specifically for Consumer B and C. Consumer B was not appropriately assessed by a suitably skilled and qualified person following a fall prior to being placed in bed. The consumer’s vital and neurological observations were not assessed in line with the organisations post fall management protocol.

I also considered, Consumer C experienced deterioration within approximately two weeks prior to the Site Audit, their regular pain relief was reviewed and changes made, and staff reported increased moaning and groaning which was observed by the Assessment Team during the Site Audit. However, no accurate and consistent pain assessment was conducted to assess effectiveness of the new medication regimen and to ensure timely identification of unmanaged pain and provision of appropriate pain relieving interventions. The representative of Consumer B expressed their concerns around efficacy of the consumer’s relieving interventions stating they often observe them to be uncomfortable.

I have also considered one consumer was not satisfied with all aspects of the provision of personal care and clinical care including around medication management.

For the reasons detailed above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, Non-compliant with Standard 3 Requirement (3)(a).

### 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 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

The Assessment Team found that overall, sampled consumers considered that 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.

Consumers interviewed had positive feedback about the range of activities on offer and felt they could suggest new activities if they wished.

Consumers confirmed they are supported to maintain their independence and engage in activities that meet their needs and preferences. Care planning documentation captures consumer needs, goals and preferences.

Staff provided examples of how they promote each consumers emotional, spiritual, and psychological well-being, with spiritual services provided at the service as well as individualised strategies to improve consumer well-being when they are feeling low. Consumers said they feel supported by staff and felt comfortable talking to staff when they needed to.

Consumers said they are supported by the service to participate in community with facilitated bus trips and outings. Staff could confirm personal relationships of importance to consumers and how they support consumers to do things of interest to them including daily activities and leaving the service independently. Activity schedules include multiple opportunities for consumers to participate in activities within the community.

Staff confirmed they have access to the clinical management system and have access to up-to-date information and are included in clinical meetings which address individual consumer care needs and current and emerging consumer risks.

Most consumers said the meals are enjoyable and meet their preferences with improvements initiated by the service to improve meals and the dining room experience. Staff described how they meet individual consumer preferences with alternatives available and an embedded process to ensure food safety requirements are met. Staff described regular maintenance is undertaken on equipment with preventative and reactive maintenance schedules in place.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, to be Compliant with all Requirements in Standard 4 Services and supports 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) Compliant

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

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

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

### Requirement 4(3)(e) Compliant

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

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers considered they feel they belong in the service and feel safe and comfortable in the service environment.

The Assessment Team observed the service to be welcoming and easy to understand with sufficient space for consumers to mobilise throughout the service with handrails fitted. Consumers said they felt safe, found the service environment clean and welcoming and were able to personalise their rooms.

Consumers said the service is clean, they can move freely indoors and outdoors and felt safe at the service. The Assessment Team observed the service environment to be clean with consumer moving freely indoors and outdoors. Staff confirmed there are preventative and reactive maintenance schedules in place with plans put forward to upgrade the service environment.

The Assessment Team observed most furniture to be clean and well maintained both indoors and outdoors. Consumer and representatives confirmed consumers felt safe using equipment provided by the service. Staff confirmed there are preventative and reactive maintenance schedules in place with an electronic system managing additional maintenance requests.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, 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 NON-COMPLIANTFeedback 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 Non-compliant as one of four specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(c) in this Standard as not met. The Assessment Team found the service was unable to demonstrate that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. 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)(c). I have provided reasons for my findings in the specific Requirements below.

In relation to Requirements (3)(a), (3)(b) and (3)(d) in this Standard, the Assessment Team found overall, sampled consumers considered they are encouraged and supported to give feedback and make complaints.

The service could demonstrate organisational wide systems to encourage and support the feedback process. Consumers and representatives are encouraged and supported to provide feedback and make complaints. Results demonstrated feedback is recorded onto a register, monitored for trends and continuous improvement opportunities and reported at relevant meetings. Staff, consumers and representatives said they are supported to provide feedback.

Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. The Assessment Team observed brochures at the entry to the service with information regarding the complaints process and access to external advocacy agencies.

Management was able to describe how the service monitors feedback and complaints through the register and discusses complaints through a range of forums including the Resident meeting and food focus groups. Management provided examples of how the complaints were used to improve the quality of care and services for individuals or across the organisation.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, to be Compliant with Requirements (3)(a), (3)(b) and (3)(d) 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) Non-compliant

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

The Assessment Team found the service was unable to demonstrate complaints are actioned in a timely manner and an open disclosure process is used when things go wrong. The Assessment Team provided the following information and evidence relevant to my finding:

* One representative advised they verbally complained to management about an incident where a consumer experienced significant distress due to staff deliberately depriving them access to their call bell. The representative was dissatisfied they did not receive a response from management either verbally or written.
* The Assessment Team’s report states management advised they said they would organise a case conference with the representative as soon as possible to discuss their concerns.
* One consumer advised, whilst they were satisfied actions taken by the service following an incident where they were deprived access to their call bell have been effective, resulting in successful prevention of the similar incidents from re-occurring, the service did not practice open disclosure and did not provide them explanation of what occurred and what the service did about it. The complaints register showed the complaint was lodged, however, was not closed off until approximately five months later which is not line with the organisation’s policies and procedures.
* One representative reported they raised a number of concerns with management about clinical and personal care provided to a consumer through electronic correspondence. However, their complaints were not always acknowledged and the outcome of complaints not provided. The representative confirmed following the most recent complaint, management responded with a proposal to arrange a case conference. However, at the time of the Site Audit they had not heard from the service or the case conference been arranged.
* The report states management acknowledged a delay in arranging a case conference to discuss concerns raised by the representative and said they would arrange a meeting following their return to the service as they are currently on leave.

The Approved Provider submitted a response to the Assessment Team’s report. While the Approved Provider acknowledges the gaps identified in the report and commenced an action plan to address the deficiencies identified by the Assessment Team, it does not agree with all statements in this Requirement and provides clarifying information.

* In relation to the complaint from the representative about a call bell not provided to the consumer, the Approved Provider advised the incident had been reported to a staff member who encouraged the representative to use a formal complaints process. However, whilst the service received a compliment from the representative, there wasn’t a complaint submitted by the representative regarding this incident. In addition, the Approved Provider asserts management had responded and followed up on the incident with staff on the day, and management had followed up with the representative the next day and documented this within the incident management system.
* The Approved Provider reported they had identified deficits in relation to the service’s compliance with this Requirement prior to this Site Audit and had been actioning remedial actions with several strategies implemented.
* The Approved Provider plans to review and update the Consumer Complaint Management Flow Chart to include provision of instruction of sharing outcome with consumer(s)/substitute decision makers within open disclosure and communication partnerships throughout process.

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

* I acknowledge the Approved Provider’s planned actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate appropriate actions are always taken in response to complaints or that open disclosure processes are effectively deployed when things go wrong.
* In coming to my finding, I have considered feedback from consumers and representatives which indicate open disclosure processes have not been effectively implemented and complainants have not had their concerns satisfactorily addressed.
* I consider the Approved Provider had not implemented effective actions in response to an incident when things went wrong to ensure changes in care and services are sustainable. As a result, a similar negative event occurred to another consumer within three-month resulting in the consumer’s emotional distress.

For the reasons detailed above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, Non-compliant with Standard 6 Requirement (3)(c).

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

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

# STANDARD 7 NON-COMPLIANTHuman 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 two of five specific requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(d) in this Standard as not met. The Assessment Team found the service was unable to demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. 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)(d). I have provided reasons for my findings in the specific Requirements below.

The Assessment Team recommended Requirement (3)(b) in this Standard as met. However, based on information and evidence presented in Standard 6 Requirement (3)(c), and the response from the Approved Provider, I have come to a different view from the Assessment Team in relation to Requirement (3)(b) in this Standard. I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, most sampled consumers consider they get quality care and services when they need them and from staff who are kind and caring.

Management was able to describe staffing systems are in place to support management with the planning and monitoring of staffing levels. Consumers, staff and representatives said they did not always feel there is enough staff, however, did not feel it impacted consumer care needs.

Consumers said they felt most staff are competent and have the necessary knowledge to perform in their roles. Management said there are policies and procedures available to guide staff in practice and monitoring systems in place to identify additional training needs and capture necessary qualifications.

Staff said they undertake performance assessments with management and have the opportunity to discuss development opportunities including additional training. Management said they have monitoring systems in place to manage staff performance with the support of the Human Resource team.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, to be Compliant with Requirements (3)(a), (3)(c) and (3)(e) in Standard 7 Human resources.

## 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.*

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

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

The Assessment Team found the service was able to demonstrate that workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Most consumers and consumers’ representatives interviewed by the Assessment Team confirmed staff interactions are kind, caring and respectful, which was observed by the Assessment Team throughout the Site Audit. Staff interviewed demonstrated a knowledge of individual consumer care needs.

However, information and evidence presented in the Assessment Team’s report in Standard 6 Requirement (c) reflects deficiencies associated with Standard 7 Human resources, specifically Requirement (3)(b) which expects that the workforce in day-to-day interactions, behave and act in a kind, caring and respectful manner. One consumer lodged a complaint about staff members depriving them of access to their call bell resulting in their distress during November 2021. Three months later during February 2022, another consumer was subject to staff being unkind and not having caring interactions when they were deprived of access to their call bell and were found by staff walking out of their bedroom in distress seeking help. The consumer’s representatives reported to the Assessment Team and to staff at the service that this is an ongoing issue. The Assessment Team provided the following information and evidence relevant for this Requirement:

* An incident report was completed in November 2021 where a consumer was found on the floor. The consumer stated they had been ringing the bell for several hours and nobody came. The consumer did not have their continence aid on, was uncovered, very anxious and distraught. On inspecting the room, a staff member found the call bell was unplugged. The consumer lodged a formal complaint in relation to the incident, however, no response was received.
* In February 2022, a similar incident occurred with another consumer being deprived access to their call bell and was found in distress. The consumer walked out of their bedroom to get staff attention. Upon investigation the consumer’s call bell was found being unplugged. The consumer’s representative confirmed they saw the call bell disconnected on a number of occasions and reported this to staff.
* Staff interviewed confirmed they were aware of concerns raised about staff members unplugging the call bells, however, stated they believed this issue was addressed by management.

The Approved Provider submitted a response to the Assessment Team’s report and included additional information in relation to actions taken by management to address issues associated with staff unplugging call bells:

* The Approved Provider reports, following the most recent incident where a consumer was found walking out of their bedroom in distress, staff were informed through communication by a member of the management team that the removing of access to a call bell is prohibited and serious disciplinary consequences will be actioned to anyone identified to have done this.

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

I acknowledge the actions undertaken by the Approved Provider to rectify to deficiencies associated with staff practices that are not kind or caring.

However, I find the Approved Provider’s actions in response to an incident where a member of workforce did not show kindness and a caring attitude, have not been effective nor sufficient resulting in re-occurrence of similar incidents.

In coming to my finding, I have considered that the way staff interacted with two consumers have had negative impact on their health and well-being and resulted in the consumers’ anxiety and distress. Depriving the consumers of access to their call bell is not an action that is kind and that lets the aged care consumer know that they are not a burden, and that all staff care enough to look after them properly. In addition, it placed one consumer at significant risk of harm when they could not get staff assistance for a prolonged period of time and were lying on the floor until staff found them. It is expected in this Requirement, the organisation responds appropriately and effectively when a member of the workforce does not show kindness and a caring attitude, which the Approved Provider could not demonstrate at the time of the Site Audit.

For the reasons detailed above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, Non-compliant with Standard 7 Requirement (3)(b).

### 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) Non-compliant

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

The Assessment Team found the service was unable to demonstrate the workforce is provided with effective training, education or support to ensure they perform their roles and responsibilities effectively to provide safe and quality care to consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* Four consumers and consumer representatives reported dissatisfaction staff have sufficient knowledge or training.
* Staff training deficits identified including pain and behaviour assessment, post fall management and restrictive practices.
* All clinical and care staff interviewed confirmed they had either received no training on restrictive practices or limited training.
* One staff member said there is no time to complete mandatory training modules online during shifts.
* One clinical staff confirmed they had not completed any training since commencing several months prior to the site audit.
* Training records confirmed significant deficits in mandatory training compliance rate especially around elder abuse, Serious Incidents Response Scheme, manual handling and restrictive practices.

The Approved Provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a continuous improvement plan which is being implemented to address the deficits. Improvements include completing and providing to individual staff members their training overdue reports and a letter outlining the requirements to complete within an allocated 2 week time frame.

The service plans to reassess any outstanding training at the end of the two weeks and where there is any outstanding training, a performance management meeting will be convened to support completion. In addition, the service plans to implement a system of monitoring and incorporate into the 6 monthly and annual staff performance reviews to support compliance.

The Approved Provider has committed to addressing the deficits identified including in relation to staff training in manual handling, recognising and reporting elder abuse and restrictive practices. However, at the time of the Site Audit, the service did not demonstrate staff were effectively trained, equipped and supported to perform their roles in line with these Standards.

For the reasons detailed above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, Non-compliant with Standard 7 Requirement (3)(d).

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

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

# STANDARD 8 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 Compliant as five of the five specific requirements have been assessed as Compliant.

Management provided monthly reports and described reporting processes that are in place to ensure the governing body can monitor and trend clinical indicators, incidents and other reported data. The organisation has a clinical governance framework with policies and procedures available to guide staff practice. Documentation provided showed how infections, restrictive practices and open disclosure are reported and monitored.

Management provided documentation and policies and procedures to demonstrate there are organisational wide governance systems in place to support the areas required within this Requirement. Staff said they have access to policies and procedures and up-to-date and relevant consumer information, with changes communicated through various methods.

The service has mechanisms in place to report all incidents, and staff interviewed were knowledgeable on how to report and document consumer and staff incidents. However, not all incidents reportable under Serious Incident Response Scheme were undertaken within legislative timeframes.

Management described systems and processes in place for the management of risk and policies and procedures available to guide staff in the practice of those processes. Management provided a risk register identifying consumer risks and risk assessments completed by staff to mitigate individual consumer risks. Staff confirmed consumer risks are communicated and incidents reported by staff within the incident management system.

The organisation has a clinical governance framework with policies and procedures available to guide staff in practice.

Based on the evidence documented above, I find Yorke and Northern Local Health Network Incorporated, in relation to Port Pirie Regional Health Service - Hammill House, to be Compliant with all Requirements in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

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

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

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

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

### Requirement 8(3)(c) Compliant

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

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

### Requirement 8(3)(d) Compliant

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

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

### 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.

The Approved Provider has acknowledged some deficits identified by the Assessment Team and have indicated and demonstrated a commitment to addressing these deficiencies. The service should seek to ensure:

* In relation to Standard 3 Requirements (3)(a):
	+ Consumers are provided with personal and clinical care which meets their needs and preferences, specifically in relation to medications, pain management and post fall management, in accordance with policies and procedures.
* In relation to Standard 6 Requirements (3)(c):
	+ Complaints are actioned and responded to, with communication and consultation with the complainant and open disclosure is used when things go wrong.
* In relation to Standard 7 Requirements (3)(b) and( 3)(d):
	+ Monitoring of staff practice effectively identifies where staff are not interacting with consumers in a kind and caring way and appropriate action is taken.
	+ Staff are supported through training and education appropriate and relevant to their roles.