Performance

Report

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| Name of service: | Port Pirie Regional Health Service - Hammill House |
| Service address: | The Terrace PORT PIRIE SA 5540 |
| Commission ID: | 6302 |
| Approved provider: | Yorke and Northern Local Health Network Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 18 January 2023 |
| Performance report date: | 2 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 Port Pirie Regional Health Service - Hammill House (**the service**) has been prepared by A Kasyan, 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 staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 13 February 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | 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. | Compliant |

Findings

The service was found non-compliant in Requirement 3(3)(a) following a Site Audit undertaken from 17 to 19 May 2022, where it was found clinical care delivered to the consumers in relation to pain and post fall management, was not safe or effective. At the Assessment Contact undertaken on 18 January 2023, the assessment team found the service have made a number of improvements to address the non-compliance including staff training, record keeping, auditing of consumer records, and review and update of the post fall management protocol.

The assessment team found, while certain improvements have been made in pain management, they were unable to demonstrate that all consumers receive safe and effective clinical care in relation to wound and skin integrity management, fluid restriction monitoring, and post falls management. The assessment team’s report included evidence and information relevant to their recommendation of Not Met, including:

Consumer A did not have their vital and neurological observations completed in accordance with the service’s falls management policy and procedure. Furthermore, the consumer was not referred to the physiotherapist for review until 7 days after the fall. In addition, there was no documented evidence to reflect when bruising was first identified.

Consumer B sustained 2 falls within 3 days. However, the consumer was not assessed by a medical officer for injuries following the first fall. The consumer was not referred to the physiotherapist for a review until after the second fall, and new falls preventative strategies, such as a pendant call bell and sensor beams were not implemented until after the second fall. Additionally, vital and neurological observations were not completed in accordance with the service’s falls management policy and procedure.

Consumer C’s wound charting document did not show if the consumer had their dressing changed in 7 days. Repositioning chart did not record repositioning occurred at the frequency outlined in the wound chart.

Consumer D’s fluid intake is restricted to 1.5 Liters per day. The consumer was on fluid intake charting which was not consistently completed.

The provider submitted a response to the assessment team’s report and disagrees with the Assessment Team’s findings. The provider’s response includes further evidence to support compliance and additional information to address some inaccuracies and omitted information. The response included the following information and evidence relevant to my finding:

In relation to Consumer A, the provider states and submitted progress notes which confirm the consumer is cognitively alert and was able to confirm they did not hit their head during the fall, leading staff to discontinue with the neurological observations.

Additionally, the provider submitted a wound care plan for Consumer A, showing photographs of bruising taken the day following the fall. Lastly, the referral for the physiotherapist was placed in time for the next planned visit which was 6 days following the consumer’s fall.

Consumer A and Consumer B were both reviewed by the physiotherapist post fall at the physiotherapist’s next scheduled visit. The provider informs the service is a rural service and does not have the same access to physiotherapists as metropolitan services. If consumers experience injuries that require urgent attention they are transferred to hospital for review. There was no requirement for Consumer A or Consumer B to be transferred to hospital.

In relation to Consumer C, whilst the repositioning daily chart did not capture repositioning of the consumer, documentation of hygiene and continence care have captured regular repositioning. Consumer C is also repositioned into their comfort chair twice daily and also for activities and for the eating of meals and return to bed. Hygiene charts and bowel charts were attached to the response to demonstrate repositioning.

In consultation with the Consumer D, prior to the assessment contact, the service updated the care plan to reflect that fluid restriction is to be monitored through twice weekly weighing which is considered best practice for monitoring patient volume status and it was in line with the consumer’s preferences.

The provider acknowledges there is an opportunity for improvement in relation to record keeping and a range of remedial actions have been put in place since the assessment contact visit, including changes to the audit tool for identification of any documentation gaps related to falls, repositioning and fluid balance daily forms. Furthermore, a new post falls checklist has been created to prompt staff on the documentation requirements and escalations and referrals post falls.

After reviewing the evidence and information presented in the assessment team’s report and the provider’s response, I have come to a different view from that of the assessment team and find requirement 3(3)(a) Compliant.

In relation to Consumer A and Consumer B, while clinical staff deviated from the post falls management protocol regarding the frequency of neurological observations, I find both consumers received safe and effective clinical care despite these deviations.

Both Consumer A and Consumer B were assessed for injuries immediately following their falls. In relation to Consumer A, progress notes demonstrate a nurse had attended to vital signs, and neurological status were stable and within normal limits, and the consumer was no in distress. The consumer’s vital and neurological observations were undertaken 10 times within 24 hours with less frequent monitoring at night time. Additionally, documentation attached to the provider’s response, including progress notes and wound management plan and evaluation, shows timely identification and ongoing monitoring of the injury (bruising) sustained by Consumer A, including pain monitoring.

Whilst I acknowledge Consumer B was not reviewed by the medical officer following the first fall within 24 hours in strict accordance with the service’s policy/procedure, the evidence and information presented in the assessment team’s report and the provider’s response does not indicate there was a clinical need for the consumer to be reviewed by the medical officer within that timeframe.

In relation to Consumer A and Consumer B, I have also considered the provider’s statement that if consumers experience injuries that require urgent attention, they are transferred to hospital for review due to remote location of the service and limited access to the specialists. There was no evidence for Consumer A or Consumer B which indicated a need for urgent medical review.

The provider submitted hygiene and continence charts to demonstrate repositioning for Consumer C, however, this documentation only indicates a position change at the time of hygiene or continence care rather than a holistic demonstration of repositioning during a full day. While I consider there are some deficits in relation to documentation of wound dressings and repositioning, I find this does not indicate there has been a failure to provide Consumer C with safe and effective care. I have also considered that the service has acknowledged there is an opportunity to improve record keeping practices and have initiated remedial actions.

In relation to Consumer D, I consider they received safe and effective clinical care tailored to their needs and reflecting the consumer’s preferences. The provider’s response included progress notes and abstracts of the care plan recording consultation held with the consumer regarding options to monitor fluid restrictions. The care plan states the consumer agreed to be in weighed two times a week and they don't want staff monitoring their intake of food or fluid.

In coming to my finding, I also took into consideration the assessment team’s finding about two of the sampled consumers who were found to be receiving safe and effective personal and clinical care, which was best practice, tailored to the consumers’ needs and optimised their health and wellbeing. In addition, the service has comprehensive policies and procedures on personal and clinical care delivery, and staff were able to describe current best practice in relation to delivery of personal and clinical care.

Whilst I am satisfied the provider demonstrates Compliance with this Requirement, I encourage them to review their processes in areas of record keeping ensuring clinical staff clearly and accurately document the reason for any deviations from the established post fall management protocols regarding the frequency of monitoring of vital and neurological observations.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The service was found non-compliant in Requirement 6(3)(c) following a Site Audit undertaken from 17 to 19 May 2022 where it was found open disclosure processes had not been effectively implemented and complainants have not had their concerns satisfactorily addressed. At the Assessment Contact undertaken on 18 January 2023, the assessment team found the service have made a number of improvements to address non-compliance, including staff training and updates to open disclosure procedures.

The assessment team found, while certain improvements have been made around how complaints are actioned and recorded, there remain deficiencies, specifically around recording of complaints. The assessment team found the service did not demonstrate appropriate action is taken in response to complaints and an open disclosure process is not used when things go wrong. The assessment team’s report included evidence and information relevant to their recommendation of Not Met which is summarised below.

One consumer said whilst they were satisfied with the resolution of their complaint, they were not informed of how their complaint was addressed. Whilst the complaint was documented in the service’s complaint management system, there was no documented evidence to show what steps have been taken to address it.

There were 2 other complaints, one raised by the consumer during the resident meeting and another one raised by the consumer’s representative through an email. These 2 complaints were not included into the complaints register.

The feedback and complaints register showed the name of complainants, date feedback was received, person/s responsible for following up issues and the nature of feedback given. However, the register did not record acknowledgement of receipt of feedback, outcomes reached, and outcomes conveyed to the complainant.

The provider submitted a response to the assessment team’s report which includes additional information to address some inaccuracies and omitted information and identified opportunities for improvement since the assessment contact, including a plan for continuous improvement.

The provider acknowledged some feedback had been managed with email responses to 2 family members which was their preferred form of communication. This type of feedback is now being managed within the electronic system for managing feedback and incidents too.

The provider asserts feedback recorded in the electronic system has an acknowledgement section and records the management and outcome of the feedback. It is acknowledged on the day of the assessment contact that a snapshot of the system was provided while awaiting a fully detailed report from the quality team.

The provider acknowledges there is an opportunity for improvement to improve capturing of the consumers’ feedback and complaints, including changes to the resident and relative meeting minutes template which prompts the capturing of any feedback in the meeting to be entered in the application that enables the service to record, manage, investigate and analyse consumer and worker incidents as well as consumer feedback.

After reviewing the evidence and information presented in the assessment team’s report and the provider’s response, I have come to a different view from that of the assessment team and find Requirement 6(3)(c) is Compliant.

Despite some deficiencies in documenting the actions taken and not recording all complaints in a single register, I have come to a view that appropriate actions are being taken in response to complaints.

Firstly, the service has comprehensive policies and procedures for handling complaints, and staff are trained in using them.

Secondly, the assessment team’s report outlines a sample of three complaints and the corresponding actions taken by the service. Although not all actions where documented or recorded in a single register, I found that the service had taken appropriate steps to address the issues raised in the complaints. These actions included conducting investigations, implementing corrective actions and providing feedback to the complainants.

Additionally, I took into account feedback from consumers and their representatives who expressed satisfaction with the actions taken by the service in response to their complaints.

While there are so deficits in relation to complaints record keeping processes, I find that overall effectiveness of its complaints handling procedures is demonstrated by the satisfaction expressed by consumers and their representatives and evidence of actions to complaints.

I am satisfied the service practice open disclosure appropriately. I took into account feedback from management in the assessment team’s report indicating that they are knowledgeable about open disclosure and encourage its use within the service. Whilst there was one incident described in the assessment team’s report where it was not explicitly documented that open disclosure was used, other evidence demonstrates the service demonstrated a commitment to transparency and accountability in its response to the incident. Management responded promptly to the complaint, indicating that they were taking steps to address it. This suggests a willingness to acknowledge mistakes and take responsibility for addressing them.

I recommend that the service take steps to improve its documentation processes, but overall, I am satisfied that the service is committed to a culture of transparency and accountability and is appropriately using open disclosure in practice.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was found non-compliant in Standard 7 Requirements 7(3)(b) and 7(3)(d) following a Site Audit conducted from 17 to 19 May 2022 where it was found staff interacted with two consumers in a way that was not kind nor caring which had negative impact on the consumers’ health and well-being and resulted in the consumers’ anxiety and distress. In addition, staff were not adequately trained and supported to perform their roles in line with the Quality Standards. At the Assessment Contact undertaken on 18 January 2023, the assessment team found the service have made a number of improvements to address non-compliance, including employing a training officer, reintroducing and updating orientation competencies, and conducting observational audits to ensure call bells are in working order and within reach of consumer.

The assessment team have evaluated the improvements that commenced at the service following the Site Audit in May 2022 and found they have been effective and addressed all issues identified at the Site Audit.

Consumers and representatives interviewed said staff are kind and caring and treat them with respect which was consistent with interactions observed between staff and consumers. Consumers said staff were competent and have the skills and knowledge to undertake their roles and provide care that meets the needs of consumers.

Processes and systems are in place to monitor consumer satisfaction with staff interactions, such as feedback forms, surveys, and Resident meetings. The feedback log showed consumer satisfaction/compliments with staff interactions and care.

Staff confirmed they are reminded by management to check call bells are in within reach prior to leaving consumer rooms. Consumer preferences and cultural requirements are documented in their care plans for staff guidance, and staff demonstrated familiarity of individual consumer needs, including their preferences, people of importance and past history.

Staff said they are provided with both online and face to face training opportunities to support them in undertaking their roles and whilst, there are some instances where they do not have a dedicated clinician to support them during the afternoon shifts, this is becoming less frequent. Management was able to demonstrate there are systems and processes for recruiting staff including the completion of an orientation checklist and completion of buddy shifts and monitoring systems to ensure training is undertaken within a timely manner, which was generally reflected within training records.

There is effective recruitment and selection processes and appropriate checks, such as police background checks, are undertaken for the workforce.

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)