Performance

Report

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| Name of service: | Riverview Lutheran Rest Home |
| Service address: | 5 Luther Road LOXTON SA 5333 |
| Commission ID: | 6065 |
| Approved provider: | Lutheran Church of Australia South Australia and Northern Territory District Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 August 2023 to 24 August 2023 |
| Performance report date: | 5 October 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 Riverview Lutheran Rest Home (**the service**) has been prepared by T Wilson, 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.

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

# 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 15 September 2023;
* the Site Audit report dated 30 August 2022.

# Assessment summary

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

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

# Areas for improvement

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |

Findings

As only Requirement (3)(b) was assessed and found to be compliant the overall assessment of this Quality Standard is not applicable.

The assessment team recommended Requirement (3)(b) to be non-complaint as changes to consumers goals, needs and preferences were not updated, including nearing end of life and the service does not have a comprehensive palliative care policy to guide staff in assessment and planning.

The report outlines how one consumer’s representative stated the consumer did not have their current goals, needs and preferences recorded. Another consumer’s care plan did not have any interventions listed for advanced care planning or palliative care. It also stated that four consumers (unnamed) who recently passed away did not have advanced health care directives /palliative care plans to guide staff in the care to be delivered at end of life.

The service responded to the assessment team report on 15 September 2023 stating they are unable to comment on any consumers that were not named which is not in line with procedural fairness as they cannot respond to the negative comments. They also provided evidence to show that the representative was emailed the latest updated care plan of the consumer. They responded and met with the service in July 2023 as they requested to discuss the care plans. Progress notes show the meeting occurred and no changes were made to the care plan.

The service also provided evidence to show that four of the five consumers that passed away in June, July and August 2023 did have advanced health directives, only one that recently entered the service recently did not. The consumer who was named did have an advanced care directive that staff were following, and explained that it was an error that the skin assessment was not updated to show the consumer as immobile, but they provided pressure area care charts to how that this was provided.

Continuous improvement was continuing with palliative care and the new policy has been released which was provided as evidence. Other initiatives continue and the information has now been consolidated and available to staff.

I have considered both the assessment team’s report and the provider’s response, and I consider the service is meeting this requirement. I was provided evidence that showed the representative was involved in a recent care plan review. It was not detailed what goals needs and preferences were missing. Whilst the service does acknowledge that the care plan was not changed for the second consumer in relation to the skin assessment, the consumer did receive pressure area care and did have an advanced care directive for staff to follow.

I also acknowledge the provider’s comment that procedural fairness was not afforded as they did not have the names of the consumers to follow up. I could not see there were systemic issues within the information provided so I did not consider those consumers.

It is for these reasons I find Requirement (3)(b), Compliant.

# 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 |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |

Findings

As only Requirement (3)(a) and (3)(c) were assessed and found to be compliant, the overall assessment of this Quality Standard is not applicable.

Requirement (3)(a)

The assessment team recommended this requirement as not met due to consumers not receiving personal and clinical care that is best practice or tailored to their needs.

* Consumer A stated they prefer to have a daily shower but just do what staff say and they don’t get one each day. There was a period of 15 days where charting showed they was showered four times. They had to wait for over 30 minutes pain medication at night and CCTV showed that staff changed their bed linen.
* Consumer B’s representative stated that continence care was not always performed so they feel responsible to do it.
* Consumer C received as required medication on five occasions in August 2023 for behaviour management but only had generic strategies for staff to follow and no behaviour support plan.
* Consumer D had ten falls in July 2023 where falls prevention strategies were not reviewed, and neurological observations were not completed as per policy.
* Consumer E had five falls in April 2023 with post fall management not completed in line with policy. An ambulance should have been called but it was not.

The service responded to the assessment team report on 15 September 2023 addressing the consumers individually.

* Progress notes showing a conversation, was held with Consumer A following the visit and they choose to keep the showering at alternate days, although it was emphasised to staff to record when they refused as it was common the consumer refused a shower and was provided a bed bath. In relation to the pain medication, CCTV was provided to the assessment team to show that the consumer was provided with pain medications in a timely manner. It was not discussed with the service the use of the CCTV in relation to continence care. Call bell records and medication records confirmed that Consumer A did receive pain medication in a timely manner.
* In relation to Consumer C about staff not knowing what non-pharmacological interventions were, the behaviour charting for the consumer showed ‘interventions trialled prior to administration’ therefore staff did now what they are they just did not know the terminology used by the assessment team.
* In relation to Consumer E’s falls the service had completed an analysis of the events that occurred following the falls and as a result the procedures were updated. Whilst the assessment team stated staff did not follow the current policy which is correct in stating an ambulance should have been called, but the policy at the time, which was provided by the service, did not state for them to do that.
* Consumer D did not have ten falls as stated by the assessment team, there were only two, with five others being incidents of where the consumer had placed themselves on the floor. Neurological observations and vital signs were provided for the two falls along with all of the seven incidents that occurred in July 2023. Two were recorded as falls, the other five were behaviour related incidents and following a general practitioner visit the consumer was referred to a geriatrician for the behaviour.

I have considered both the assessment team’s report and the provider’s response and although there have been several issues raised, I find the service is meeting this Requirement.

For Consumer A the service followed up the comments about wanting a shower each day and the consumer was satisfied with what was currently occurring. Pain medication was provided in a timely manner and the CCTV footage showing staff changing the linen could only demonstrate that continence care was being attended to.

Whilst Consumer B’s representative stated continence care is not always performed there was no further detail provided. The assessment team stated the care plans say regular toileting is to occur and it did evidence that the consumer is regularly assisted to the toilet and continence aids are changed.

Whilst it was stated that Consumer C did not have a behaviour support plan, the report did state that the interventions were generic and not personalised. This information tells me that there is somewhere that this information is available to staff, although, it may not be called a behaviour support plan. Whilst it was said the strategies were generic, there was no information to show, besides the administration of as required medication, that the strategies were not effective. The context around the administration was not provided such as how often the behaviours occur where strategies are required or what was not effective.

Consumer D’s two actual falls were treated as per the service’s policy as evidenced by the documents provided. I am satisfied that the other five incidents were treated as incidents as opposed to falls as evidenced by the documentation.

The service acknowledged the deficits in relation to Consumer E’s falls and where gaps were identified actions have been undertaken such as, a new falls policy, training and reminders to staff about processes. They have recognised the deficits and taken action to correct them and provide staff with better guidance.

Overall, I am satisfied based on the information above that consumers did receive effective care.

It is for these reason I find Requirement (3)(a), Compliant.

Requirement (3)(c)

The assessment team recommended this Requirement as non-compliant as the service did not demonstrate regular monitoring of consumers at end of life to ensure their needs, goals and preferences are recognised and addressed, their comfort maximised, and their dignity preserved. The assessment team reviewed four care files, however, only one consumer was named. For the named consumer they stated they did not have a palliative care plan and progress notes did not evidence repositioning, hygiene care or mouth care was provided during the period before their passing. The evidence provided by the assessment team spoke about the consumer becoming unwell which was followed by the registered nurse and a referral made to the general practitioner for urgent review, but the progress note showed this did not occur until the following evening. Other information regarding referral to the general practitioner was also included.

The service responded to the assessment team report on 15 September 2023 but did not directly respond to the comments made by the assessment team. However, they did provide the information to show that the named consumer did have an advanced health directive in place which the service stated they followed. They provided narration in relation to the continuous improvement with palliative care and provided a copy of the new policy.

I have considered both the assessment team’s report and the response and based on the information provided I cannot say the consumer did not get the care as stated by the assessment team. The information that was documented actually did show the consumer was monitored on the last few days before passing given they were referred to the general practitioner twice in four days and staff had asked for additional assessment to be completed by the registered nurse which resulted in the referrals.

I also acknowledge that the service had previously identified issues with palliative care and have taken steps to address the issues with the clinical manager working specifically on the project. A new more comprehensive policy is now in place and additional steps are being taken to enhance palliative care further.

It is for these reasons I find Requirement (3)(c), Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

As only Requirement (3)(g) was assessed and found to be compliant the overall assessment of this Quality Standard is not applicable.

Consumers confirmed they feel safe using the equipment provided which was observed to be clean and in good repair. Staff stated there is sufficient equipment to support them in their roles and they know how to report faults and maintenance concerns. There is both a proactive and reactive maintenance program which is up to date.

It is for these reasons I find Requirement (3)(g), Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |

Findings

As only Requirement (3)(a) was assessed and found to be Compliant the overall assessment of this Quality Standard is not applicable.

Whilst not all consumers and representatives felt comfortable to raise complaints to management, the service’s systems show that feedback and complaints have been captured through verbal complaints, email, social media and resident meeting forums. A survey conducted in July 2023 shows that all 56 consumers who responded always felt comfortable raising a complaint. Staff could describe the complaint process and what to do if someone raises an issue.

It is for these reasons I find Requirement (3)(a), Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

As only Requirement (3)(c) was assessed and found to be Compliant the overall assessment of this Quality Standard is not applicable.

Overall, consumers confirmed they felt confident staff delivered care and services competently. Management described recruitment process to ensure new staff are competent to perform their role and how they ensure staff have appropriate qualifications, including annual checks for current clinical registrations. Ongoing education is provided to the workforce to ensure their knowledge is current and applicable to their duties.

It is for these reasons I find Requirement (3)(c), Compliant.

# Standard 8

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

Findings

As only Requirement (3)(d) was assessed and found to be compliant the overall assessment of this Quality Standard is not applicable.

The assessment team recommended this Requirement as not met. High impact or high prevalence risks were not identified and escalated, or appropriate protections and safeguards implemented to mitigate risks, and incidents were not always reported or escalated to SIRS when required by legislation.

The report asserts that despite having meetings the service have failed to identify risks, deficits in care, concerns and trends, and alert leadership in relation to end of life care, falls and behaviour management strategies for individual high-risk consumers and there were two incidents which should have been reported to the serious Incident Response Scheme (SIRS).

The service responded to the assessment team report on 15 September 2023 where commentary explains how the risk meetings are held and how the clinical continuous improvement plan where the risk are recorded are not in the minutes but are an attachment to them. This is where the actions taken, and effectiveness of risk mitigation is recorded, and comments made on the day by the assessment team stated there was a good flow of information. In relation to SIRS the service stated that the reporting tool was used to determine whether the two incidents mentioned should be reported and both did not fit Priority 1 category and only one fitted into Category 2 and it was reported within the 30 days as evidenced by the submission.

I have considered both the assessment team report and the provider’s response, and I find that the service is compliant. I have also considered my assessment in Standard 3 Requirement (3)(a) and (3)(c) to support my findings.

Whilst the assessment team asserts that risks are not identified or escalated, information from Standard 3 shows they are. Following Consumer E’s falls in April 2023 the service undertook an analysis and found deficits, so they updated the policy to guide staff better. The service has also identified issues with information available to guide staff in palliative care and a current project is underway to consolidate the information, a new policy has been released and procedures and guidance is currently being updated.

In relation to the SIRS reporting, it is not for me to determine whether reporting should have been completed. The service stated they have used the tool to determine whether is should be reported or not so I can only see they are following process.

It is for these reasons I find Requirement (3)(d) Compliant.

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