Performance

Report

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| Name of service: | St Andrews Village Hostel |
| Service address: | 95 and 81 Groom Street, HUGHES ACT 2605 |
| Commission ID: | 2913 |
| Approved provider: | Presbyterian Church (ACT) Property Trust |
| Activity type: | Assessment Contact |
| Activity date: | 11 October 2022 to 12 October 2022 |
| Performance report date: | 14 November 2022 |

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 St Andrews Village Hostel (**the service**) has been prepared by Katrina Platt, 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; the assessment contact report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved Provider’s response to the assessment team’s report received 20 October 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **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 | **Non-compliant** |
| **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

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.

* Requirement 3(3)(a) – ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to their needs and optimises their health and well-being particularly for wound care management, behaviour support and management of restrictive practices and post-falls monitoring and management.
* Requirement 7(3)(a) – ensure the workforce is planned to enable, and the number of mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services provided to consumers.

# 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. | Non-compliant |

Findings

The Assessment Team found clinical care for falls management, wound management and management of restrictive practices was not best practice, tailored to the individual needs of consumers and did not optimise their health and well-being. Whilst one consumer interviewed expressed satisfaction with the care provided for wound management, on review of the consumer’s wound care plan the Assessment Team observed wound care frequency did not occur in accordance with specialist directives and found information deficiencies in the wound management plan for wound measurements, wound photographs and specialist review.

The Assessment Team reviewed behavioural support plans for 2 consumers under chemical restraint and found the plans were generic, contained medication charting errors and lacked specific detail relevant to the individual consumers. Monitoring of restrictive practices as a measure of last resort was not evidenced. Medication side-effects were not considered and non-pharmacological interventions not personalised. Informed consent from the consumer, consumer representative or supported decision-maker were not evident for both behaviour support plans. The Assessment Team noted the psychotropic register was under review, with information incomplete and located across multiple areas. Management acknowledged improvements were required for psychotropic medication and behaviour support plan management.

The Assessment Team found post-fall monitoring did not occur in line with organisational policy and procedure. Neurological observations were not conducted when required and at times not recorded. Subsequent reporting of unwitnessed falls to medical officers and consumer representatives were not always completed and analysis or evaluation of falls risks were also not identified. Unwitnessed falls were not always recorded in the incident management system.

The Approved Provider responded to the assessment contact findings and noted wound care procedures have been revised, particularly for wound photography to ensure wound measurements are included in every photograph and the clear labelling of photographs including location, date and time. The wound care plan for the consumer discussed in the assessment contact report will be reviewed to capture consumer preferences about wound dressing frequency.

The Approved Provider acknowledged the gaps in the psychotropic register and behaviour support planning and advised a process improvement activity is underway. On the issue of informed consent, the Approved Provider advised informed consent was obtained in October 2022 for one of the consumers who requires chemical restraint as required. For the other consumer noted in the report, the Approved Provider disagreed informed consent had not been provided and advised information had previously been provided to the consumer’s Enduring Power of Attorney about the use of restrictive practices and informed consent obtained.

The Approved Provider advised post-falls management occurs in line with the Preventing Harm Initiative Guidelines and associated flow charting and discussed the varying requirements of the guidelines for neurological monitoring compared to those noted by the Assessment Team. The Approved Provider noted the variation and frequency of neurological observations dependant on initial clinical assessment post-fall. The Approved Provider acknowledged the electronic records system requires changes to ensure post-falls management is reflective of the Preventing Harm Initiative Guidelines.

I acknowledge the response from the Approved Provider and initiatives underway to improve clinical processes for wound management, behaviour support planning and post-falls monitoring and note improvements to clinical practices may take time to embed and impact on the provision of safe and effective personal and clinical care for consumers. I find this requirement is non-compliant.

# Standard 4

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

Findings

Overall, consumers interviewed provided positive feedback about the meals and said they were of sufficient quantity and most consumers and consumer representatives described there was sufficient variety and choice in meals. Staff interviewed demonstrated an understanding about the specific dietary needs of consumers and dietary information held about consumer needs, likes and dislikes was consistent with consumer care plans and service records. Menu planning is dietician approved and made in consultation with consumers and consumer representatives through consumer meetings and consumer feedback.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers interviewed discussed improvements made as a result of feedback or complaints and one consumer described improvements made to food quality and options when feedback was given to management. Management described complaints escalation processes were used to improve the quality of care and services provided to consumers and detailed several examples where feedback or complaints had resulted in improvements to outdoor recreational facilities, cleaning routines, community activities, personal care aids and equipment and carpet and communal furniture replacement. On review of the feedback data and comments and complaints register, the Assessment Team found complaints were resolved in a timely manner.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Non-compliant |

Findings

Most consumers and consumer representatives interviewed were dissatisfied with staffing numbers and staff responsiveness to their care needs. Whilst consumers and consumer representatives described staff as kind and caring, staff were rushed and were too busy to meet their individual care needs and preferences. One consumer described waiting extended periods for assistance with mobilisation and continence care which caused discomfort, whilst another consumer described delayed medication administration and personal care needs provision.

Staff interviewed discussed delayed responses to call bells and lack of clinical staff coverage which impacted quality care provision. Staff noted insufficient staffing available across shifts to meet all consumer needs and the provision of care which was both rushed and delayed, often impacting on the dignity of consumers.

The Assessment Team observed call bell wait times exceeded organisational policy requirements. Management discussed receipt of daily call bell reports and weekly staff discussions about response times and the plan for continuous improvement has been updated to include development of a call bell monitoring process. The revised Call Bell Alarm system policy will be reviewed. Staff were reminded of the mandatory requirements for call bell responses and toolbox education talks were pending for all staff. Changes were being implemented to call bell reporting and investigation, with oversight conducted by care managers and the clinical leadership team and registered nurses. Rosters were being reviewed to ensure more staff availability across all shifts.

The Assessment Team observed insufficient staff available during staff handover. Management acknowledged gaps in the handover process and a change of process action plan would be commenced to ensure the availability of staff members during handover, with monitoring by registered nurses and oversight by the clinical leadership team.

The Approved Provider responded to the findings by acknowledging the views of consumers and consumer representatives about the lack of timely response to care needs. Active recruitment for both registered nurses and personal care assistants is being undertaken. The Approved Provider noted the several initiatives identified in the assessment contact report have been implemented including review of staff rosters, review of the Call Bell Alarm System policy, improved monitoring and reporting of call bells including discussions in daily meetings, weekly staff meetings and daily shift handovers. Additional staff toolbox talks have occurred. Daily monitoring of the call bell exception reports is occurring, with clear escalation pathways also in place to respond to and investigate causation.

I acknowledge the measures taken by the Approved Provider to improve call bell response times and call bell monitoring and the various other initiatives proceeding. I also note recruitment is underway to address staff sufficiency and workforce. These measures will take time to impact the delivery and management of safe and quality care and services to consumers and as such I find this requirement is non-compliant.

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