St Paul's Lutheran Hostel

Performance Report

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**Commission ID:** 6157

**Provider name:** St Paul's Lutheran Homes Hahndorf

**Site Audit date:** 30 May 2022 to 1 June 2022

**Date of Performance Report:** 6 July 2022

# Performance report prepared by

Michelle Glenn, 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** | **Non-compliant** |
| Requirement 2(3)(a) | Non-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) | Non-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** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-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 consumers, representatives, staff, management and others;
* the provider’s response to the Site Audit report received 22 June 2022; and
* the Performance report dated 16 September 2021 for the Assessment Contact undertaken from 13 July 2021 to 14 July 2021.

# STANDARD 1 COMPLIANT Consumer 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 the six specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that 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.

All consumers and representatives sampled were complimentary about how consumers are treated and described staff as ‘kind,’ ‘respectful and professional’. Consumers indicated their individuality, culture and diversity was valued and described being able to choose their own level of participation in various activities and how they are supported in their choice to follow individual pursuits. Consumer files sampled included individualised information about aspects of consumers’ social, cultural, and spiritual needs and preferences and how they wish to spend their time. Staff spoke about consumers in a respectful manner and demonstrated an awareness of their backgrounds and likes and dislikes. Staff also demonstrated an understanding of cultural safety and described how this influences delivery of care.

Consumers confirmed staff value who they are, understand their needs and preferences and enable them to feel respected, valued and safe. Staff spoke about consumers in a manner that indicated respect and an understanding of consumers’ diverse needs, and demonstrated awareness of what it means to provide culturally safe care and services.

The Assessment Team observed staff promoting choice and independence when interacting with consumers and documentation sampled demonstrated consumers are consulted and involved in making and communicating decisions regarding their care and service delivery. Care staff described how they regularly engage consumers in making informed choices about their care and services through informal conversations in everyday care. Consumers confirmed they are supported to exercise choice and independence, communicate their decisions, and decide who is involved in their care and are supported to make connections with others and maintain relationships of choice.

Consumers confirmed they are supported to take risks to enable them to live the best life they can. Where a consumer chooses to engage in an activity with an element of risk, consultation with consumers and/or representatives and Medical officer and/or Allied health professional occurs, risk assessments are completed outlining risks involved and management strategies are developed.

## Consumers confirmed information is provided and communicated to them to enable them to make choices about the care and services they receive. Consumers receive information through a number of avenues, including meeting forums and noticeboards. Staff descried how information is provided to consumers and how they assist consumers to understand the information. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, 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 NON-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 Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) in this Standard as Not met. The Assessment Team were not satisfied the service demonstrated 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, specifically in relation to falls and pressure injuries.

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 finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered they feel like partners in the ongoing assessment and planning of their care and services.

Consumer files sampled identified consumers’ current needs, goals and preferences, and detailed individualised strategies for meeting their needs. Advance care directives were documented and incorporated into risk profiles and end of life wishes had been captured and addressed. Review processes ensure information remains current and reflective of consumers’ current care and service needs. Consumers sampled confirmed their needs, goals and preferences had been recognised and influenced the delivery of care.

Care files demonstrated staff work with consumers and/or representatives to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Medical officers and Allied health professionals was also noted. Consumers confirmed they or their representatives are involved in discussions regarding their care and services and were satisfied the process is based on ongoing partnership.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers. Consumers and representatives sampled confirmed staff have discussed consumers’ care plans with them and outcomes of assessment and planning are communicated.

There are processes to ensure care plans are up-to-date and meet consumers’ current needs, including when changes are required due to an adverse event or a change health condition. When circumstances had changed, or incidents occurred reassessments had been completed, care plans updated, management strategies reviewed, charting commenced (where appropriate) and Medical officers, Allied health and next of kin notified.

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

**Assessment of Standard 2 Requirements**

**Requirement 2(3)(a) Non-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.*

The Assessment Team were not satisfied the service demonstrated 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, specifically in relation to falls and pressure injuries. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* On entry, a falls risk assessment was not completed nor following review by clinical and Allied health staff. A falls risk assessment was completed during the Site Audit.
* Progress notes indicate the consumer was visually assessed on entry and identified as a falls risk by clinical staff. A review by Allied health staff occurred the following day, identifying reduced mobility and vision impairment. A functional assessment completed four days post entry identified the consumer at risk of falls due to visual impairment and physical weakness.
* Four clinical staff and three care staff sampled were not familiar with Consumer A’s mobility status or falls risk.
* A head to toe and skin assessment completed on entry was not documented and had not identified an existing pressure injury. A skin assessment was not completed until three days post entry.
* The consumer confirmed they entered the service with an established pressure injury, which had a pre-existing dressing and had informed staff on day one.
* Three care and one clinical staff were not aware the consumer had a pressure injury.

Consumer B

* A skin assessment dated April 2022 stated no pressure injury had been identified, despite the consumer having regular dressings for stage II pressure injuries.
* Photographs of the wounds demonstrate dressings were present in another area on two occasions in February 2022, with a large blister evident on the area in March 2022. The wound to this area was not assessed and documented until seven days following the photograph demonstrating a blister.
* Wound charting and the management plan did not indicate further management strategies had been implemented to promote healing and photographs do not demonstrate the wound is healing.

Consumer C

* Progress notes indicate the consumer had an area of impaired skin integrity, however, this was not formally assessed.
* An incident report in April 2022 indicates a stage II pressure injury was found, however, no further assessment was arranged. The stage II pressure injury was not assessed and documented in an incident report or wound management plan until 21 days later.
* Progress notes in May 2022 indicate a change in the consumer’s skin integrity and treatment strategies initiated.
* A skin assessment dated May 2022, 13 days after the progress note, identified the consumer at moderate risk of pressure injuries and indicated the consumer did not require pressure area care, despite identifying the existing stage II pressure injury and listing pressure relieving devices as strategies.

Consumers A and D

* Acute care needs/care support plans and Diabetic management plans contained outdated and conflicting information.
* Care documentation sampled demonstrated staff had been following medical directives as documented in the more recent diabetic management plans and this was confirmed by clinical staff interviewed.

The provider acknowledged the Assessment Team’s recommendation of not met, and indicates the service continues to address and correct these requirements. The response included commentary and documentation demonstrating corrective actions initiated and ongoing. Additionally, the response included a Plan for continuous improvement directly addressing deficits identified by the Assessment Team, as well as planned actions and outcomes. The provider’s response included, but was not limited to:

* Mandatory training planned in relation to wound management, skin integrity and pressure injuries.
* Consumer A’s Hospital discharge summary had no skin impairment documented and an entry skin integrity assessment was completed. There were no Physiotherapists on the day of entry, however, a functional assessment was completed the following day, but not a falls risk assessment.
* Consumer B’s skin assessment had not been identified and assessed in a timely manner.
* Consumer C’s wound was incorrectly entered as a stage 2 on the incident report.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, assessment and planning processes did not consistently inform the delivery of safe and effective care and services, specifically in relation to Consumers A, B and C. Insufficient information relating to care needs and risks to consumers’ health and well-being was noted in assessments and/or care planning documents, used by staff to guide provision of consumers’ care and services.

In relation to Consumer A, I find assessment and planning processes have not been effectively undertaken or initiated in line with the service’s processes, specifically in relation to skin integrity. I acknowledge the provider’s response indicating the Hospital discharge summary did not indicate any skin integrity issues on entry. However, documentary information should not be the sole source of information relied upon when considering a consumer’s health and condition. I note a head to toe assessment was completed on entry, however, not documented. I have considered that this observational assessment was not undertaken thoroughly as an existing pressure injury was not identified at this time. As such, implementation of appropriate, individualised strategies to minimise further deterioration of the consumer’s skin integrity were delayed.

The provider’s response acknowledges there was a delay in completing a falls risk assessment for Consumer A. However, I find appropriate, initial assessment of the consumer’s mobility status occurred on entry through a progress note identifying the consumer’s mobility and transfer requirements and some falls minimisation strategies. Further strategies were identified following an Allied health review the day following entry.

In relation to Consumer B, I find assessment and care planning processes have not been effectively undertaken. A pressure injury had not been identified or assessed, despite a photograph taken seven days prior demonstrating skin impairment to the area. Additionally, the wound chart and management plan did not demonstrate further management strategies had been considered and/or implemented to promote wound healing.

In relation to Consumer C, I acknowledge the provider’s response indicating identification on an incident report in April 2022 was an error. However, despite identification of changes to the consumer’s skin integrity in May 2022, an incident report and wound management plan were not implemented until four days later.

In relation to diabetes management documentation for Consumers A and D, I have considered that while documents included conflicting information, staff were in fact following the most current directives.

I acknowledge the actions taken by the service in relation to the deficits highlighted both at the time of the Site Audit and since receiving the Assessment Team’s report. However, I have considered that these actions were initiated subsequent to the Site Audit and not as a result of the service’s monitoring processes, including care plan review and audit processes.

For the reasons detailed above, St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

**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-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant.

Requirements (3)(a) and (3)(b) in this Standard were found Non-compliant following an Assessment Contact – Site undertaken from 13 July 2021 to 14 July 2021 where it was found the service did not demonstrate:

* consumers get safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being; and
* high impact or high prevalence risks associated with the care of each consumer were effectively managed.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified. However, at the Site Audit, the Assessment Team recommended Requirements (3)(a) and (3)(b) not met. The Assessment Team were not satisfied the service demonstrated:

* clinical care is consistently best practice and optimises health and well-being, specifically in relation to falls management, wound care and use of psychotropic medication; and
* effective management of high impact or high prevalence risks associated with the care of each consumer, specifically behaviour management.

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)(a) and (3)(b). I have provided reasons for my finding in the specific Requirements below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, most sampled consumers considered that they receive personal care and clinical care that is safe and right for them.

Care files sampled demonstrated expressed needs, goals and preferences of consumers’ nearing the end of life had been recognised and addressed. Staff described how the delivery of consumers’ care and services is altered during end of life and spoke in a manner indicating dignity and respect. Progress notes and End of life pathway charting demonstrated ongoing monitoring and review of a consumer’s condition and frequent discussion and engagement with representatives and the Medical officer.

Appropriate management of consumers’ care needs and timely referrals to Medical officers and/or Allied health professionals were noted in care files sampled. Additionally, where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff.Consumers and representatives confirmed appropriate and prompt action had been taken in response to deterioration in consumers’ health, including assessments, observations, medical reviews and transfer to hospital, where appropriate.

Care files demonstrated information about consumers’ condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. Progress notes included ongoing commentary relating to changes in consumers’ condition, needs and preferences. Information relayed from Medical officers and Allied health professionals had been considered and consumer care plans updated accordingly.

Infection prevention and control measures have been embedded, in addition to antimicrobial stewardship principles to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. Care and clinical staff described practical strategies to minimise spread of infection and demonstrated knowledge and understanding of antimicrobial stewardship principles. The service has experienced two COVID-19 outbreaks and documentation demonstrated consumers who tested positive were regularly monitored, vital sign observations were recorded, food and fluid intake monitored and emotional support provided.

Based on the evidence documented above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Compliant with Requirements (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 were not satisfied the service demonstrated consumers receive safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to falls management, wound care and psychotropic medication. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer C

* Care documentation did not show psychotropic medication was used as a last resort and the consumer’s representative expressed concern regarding an observed increase in drowsiness.
* The Behaviour support plan was a repeat of the behaviour assessment and did not reference restrictive practice. The care plan outlined each identified behaviour, its cause and interventions, however, did not contain information in relation to restrictive practices or reference psychotropic medication.
* Staff have administered psychotropic medication frequently in response to ‘agitation’ and had not demonstrated its use as a last resort
* Progress notes document psychotropic medication was administered on 11 occasions over an approximate 15 day period. On only one occasion staff documented they had tried non-pharmacological interventions first.
* Progress notes indicated staff had not consistently followed the service’s procedure following two incidents. Incident forms were not completed, neurological observations were not recorded and representatives and the Medical officer were not notified.

Consumer E

* Progress notes viewed demonstrated staff had not consistently followed the service’s post falls procedure following an incident in May 2022. An incident form was not completed, neurological observations were not recorded and representatives and the Medical officer were not notified.

Consumers B and C

* Wound care documentation is not consistent with best practice as outlined in the service’s procedure. For Consumers B and C, measurements were not consistently documented, photographs were not consistently taken from the same angle nor include a ruler and staging or classification was not consistently documented.

The service was found Non-compliant with Requirement (3)(a) following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021, where it was found the service did not ensure each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of diabetes, falls, continence and food and fluid charting. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, introduced an insulin stock checklist; reviewed and updated all diabetic management plans; revised and updated falls prevention and management policies and procedures, including development of flowcharts and a post falls clinical pathway; and provided staff with education relating to use of non-pharmacological strategies prior to use of psychotropic medication.

The provider acknowledged the Assessment Team’s recommendation of not met, and indicates the service continues to address and correct these requirements. The response included commentary and documentation demonstrating corrective actions initiated and ongoing. Additionally, the response included a Plan for continuous improvement directly addressing deficits identified by the Assessment Team, as well as planned actions and outcomes. The provider’s response included, but was not limited to, training relating to wound management has been organised and meetings relating to falls management have been arranged; restrictive practices has been incorporated into electronic Behaviour support plans; and discussions held with Allied health staff relating to falls management processes.

I acknowledge the provider’s response. However, I find at the time of the Site Audit the service did not demonstrate safe and effective clinical care that is best practice, tailored to consumers’ needs and optimises their health and well-being, specifically in relation to psychotropic medications, falls management and wound care.

I have considered that for Consumer C, clinical care has not been provided in line with best practice or in a way which optimised the consumer’s health and well-being. The Behaviour support plan was not reflective of legislative requirements and documentation indicated that psychotropic medications, used to influence behaviour, were not used as a last resort. Progress notes indicate of the 11 occasions psychotropic medication had been administered, there was evidence that non-pharmalogical interventions had been trialled prior to administration on only one occasion.

In relation to falls management for Consumers C and E, I have considered that the consumers’ health and well-being has not been optimised. I find staff did not provide care post falls in line with the service’s processes. There was no evidence that neurological observations had been undertaken or that the Medical officer or representatives were notified following the incidents. As such, the consumers’ health and well-being post incidents has not been effectively monitored to enable changes in health and condition to be identified and appropriate actions to be implemented in a timely manner.

In relation to wound management for Consumers B and C, I have considered that clinical care has not been provided in line with best practice processes or that wounds have been reviewed in line with the service’s processes. Consumers should expect their wounds to be monitored at each treatment, including measurements of the wound undertaken. Such practices would ensure wound progression is monitored, wound deterioration is identified in a timely manner and actions taken accordingly.

I acknowledge the actions taken by the service in relation to the deficits highlighted since receiving the Assessment Team’s report. However, I have considered that these actions were initiated subsequent to the Site Audit and not as a result of the service’s own monitoring processes.

For the reasons detailed above, St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

**Requirement 3(3)(b) Non-compliant**

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

The Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer, specifically behaviour management for one consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer C

* Staff described the consumer as frequently crying out and ‘not settling’ unless someone is present with them.
* Staff had documented 32 episodes of changed behaviours in 10 days. Of the 32 episodes, interventions were noted to be effective on only five occasions. Where interventions were not effective, staff had not documented follow up action.
* Consumer C was assessed by behavioural specialists in March 2022 and recommendations made. However, recommendations have not been incorporated into the consumer’s care plan with clinical management indicating it is on their list to do.
* Two clinical staff stated behaviour charts are viewed daily and said they had not yet seen the specialist’s recommendations, however, believed the Medical officer was adjusting medication.
* Care staff said they turn to clinical staff when interventions do not work and considered current strategies are ‘not really working’, including use of medication.

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021, where it was found the service did not ensure high impact or high prevalence risks associated with the care of each consumer were effectively managed, specifically in relation to management of falls and pressure injury prevention. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, created a Registered/Enrolled nurse with clinical policies, procedures and flow charts to guide staff, including in relation to falls management; communication to staff reminding them of best practice and responsibilities; provided education to staff on wound management; and introduced a high risk register to identify all high risk consumers, including those with recurrent falls and chronic pressure injuries.

The provider’s acknowledged the Assessment Team’s recommendation of not met, and indicates the service continues to address and correct these requirements. The response included commentary and documentation demonstrating corrective actions initiated and ongoing. Additionally, the response included a Plan for continuous improvement directly addressing deficits identified by the Assessment Team, as well as planned actions and outcomes. The provider’s response included, but was not limited to, providing education and training relating to effective behaviour management; and notifications to staff in relation to ineffective interventions and requirement to follow-up effectiveness of medications administered. Additionally, the response indicates specialist behaviour management recommendations were put in place for Consumer C, however, some were not effective. A further referral for review has been initiated.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, high impact or high prevalence risks associated with the care of each consumer were not effectively managed.

In coming to my finding, I have considered that Consumer C’s responsive behaviours have not been effectively managed. Care staff sampled considered current behaviour management strategies were ‘not really working’. This was supported by documentation which demonstrated interventions implemented by staff to manage Consumer C’s responsive behaviours were mostly ineffective on the majority of occasions. However, there was no evidence to demonstrate management strategies had been reviewed and new strategies implemented despite clinical staff indicating behaviour charts were reviewed daily.

I have also considered the provider’s response indicating following a specialist review in March 2022, specialist’s behaviour management recommendations were put in place, however, some were not effective. However, the provider’s response did not include evidence to demonstrate these recommendations had been incorporated into the consumer’s care plan to assist staff in delivery of care. The Assessment Team’s report indicates the care plan did not include the specialist’s recommendations and two clinical staff indicated they had not yet seen the recommendations.

I acknowledge the actions taken by the service in relation to the deficits highlighted since receiving the Assessment Team’s report. However, I have considered that these actions were initiated subsequent to the Site Audit and not as a result of the service’s own monitoring processes.

For the reasons detailed above, St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

**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 overall, consumers sampled considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

Care files sampled included consumers’ goals, lifestyle and well-being preferences, important relationships and needs and preferences in relation to emotional, social, spiritual, and cultural support. Staff demonstrated an understanding of individual consumer's needs, preferences, life experiences, and interests and described how they support consumers when they were unwell or upset. Consumers indicated staff were supportive of their emotional, spiritual, and psychological well-being and confirmed staff regularly check on their well-being.

Consumers are provided with appropriate services and supports for daily living, including participating in their internal and external communities, doing things of interest them and maintaining social and personal relationships within the service and in the community. Activity calendars are maintained and consumers were observed to participate in a range of activities throughout the Site Audit. Consumers said they enjoy attending activities, when they choose to do so.

Consumer files demonstrated information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely referrals are initiated. Consumers indicated their condition, needs and preferences are known by staff.

Most consumers and representatives were satisfied meals provided are varied and of suitable quality and quantity. Meals are prepared and cooked fresh on site in line with a four-week rotating seasonal menu. Care files reflected consumers’ dietary needs and/or preferences, including allergies, likes and dislikes and there are processes to ensure these are known by staff, including kitchen staff.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Internal monitoring processes ensure equipment provided is maintained. All consumers confirmed equipment used to provide care and services, including their individual equipment, is safe, clean, and well maintained

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, 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 sampled considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The Assessment Team observed the service environment to be welcoming and easy to understand, and to optimise each consumer’s sense of belonging, independence, interaction and function. Consumers are accommodated in single rooms with ensuite and consumer rooms were observed to be furnished with personal belongings and decorated with items relevant to consumers’ taste and lifestyle. Adequate signage was observed to assist consumers and visitors to navigate around the service. There is ample space for consumers to sit or participate in activities in various communal spaces and outdoor areas. All consumers sampled indicated they feel safe and comfortable in the service environment with one consumer describing the environment as ‘homely’.

The service was observed to be safe, clean, well maintained and comfortable and the service environment supports free movement of consumers both indoors and outdoors. Consumers were observed utilising various areas of the service throughout the Site Audit. Outdoor areas are well maintained with tidy gardens, covered gazebo areas and even pathways. Cleaning of consumer rooms and common areas is undertaken and COVID-19 protocols, including increased in cleaning of high touch points, have been implemented. Consumers and representatives expressed satisfaction with the standard of cleanliness and access to both indoor and outdoor areas and stated they feel safe in the service environment.

Furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumers. Staff described how they ensure the service environment and equipment is safe, cleaned and maintained. Preventative and reactive maintenance processes are in place and staff described how they report and manage maintenance issues, as well as hazards. Contracted services are utilised to maintain and inspect aspects of the environment and equipment. Consumers confirmed furniture, fittings and equipment are maintained and suitable to their needs and they feel safe when staff use equipment for their care and service needs.

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, 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 COMPLIANT Feedback 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 Compliant as four of the four specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken.

Consumers were aware of and had utilised the service’s feedback and complaints process and indicated they felt comfortable to raise concerns or give feedback, including negative feedback. Three consumers stated they raise issues through consumer meeting forums. Staff described how they respond to complaints or feedback raised by consumers and/or representatives, including completing feedback forms on the consumer’s behalf or escalating issues to management. Resident meeting minutes demonstrated consumers are supported and encouraged to provide feedback and raise concerns through these forums.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and on an ongoing basis through consumer meeting forums. Feedback forms and external complaints and advocacy information was also observed on display within the service. Two consumers were aware of alternate feedback and complaints avenues, however, indicated they had never found a need to use external services, as staff are very receptive.

Feedback and complaints documentation sampled demonstrated appropriate action, including an open disclosure approach is taken when things go wrong. Policy and procedure documents are available to guide staff practice in relation to management of feedback and complaints and open disclosure. Management described the organisation’s approach to open disclosure and three representatives sampled indicated an open disclosure processes had been undertaken in response to consumer incidents. Consumers expressed satisfaction with actions taken in response to feedback or complaints raised.

Feedback and complaints are reviewed and used to identify and drive continuous improvement. Management described how action items from meeting forums, including consumer meetings is used to inform the continuous improvement plan and provided examples of improvements initiated in response to feedback. Consumers stated they feel management listen and respond to their feedback.

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Compliant with all Requirements 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) Compliant

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

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

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

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

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

The Assessment Team found overall, sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The service demonstrated the workforce is planned to enable the delivery and management of safe and quality care and service with consideration to the number and mix of members of the workforce by management, rostering staff and the nursing staff in charge of each shift. There are processes to manage planned and unplanned leave. While five staff stated they do not have enough time during the shift to get all work done, they indicated this did not impact consumers’ care and service needs.

Staff interactions with consumers were observed to be kind, caring and respectful. The service’s mission, vision and values are linked to care, with recruitment focused on staff kindness. Management described how staff are rostered and allocated to ensure the best fit with consumers’ cultural identity and preferences. Consumers described staff as kind, caring and respectful in their interactions and when delivering care.

The service has processes to ensure the workforce have the qualifications and knowledge to effectively perform their roles. Staff onboarding processes include appropriate checks, buddy shifts and checklists to confirm competency with key duties. Position descriptions are available and outline roles and responsibilities, qualifications and training, including mandatory components. Staff stated they have access to education modules online and additional training opportunities are provided, including informal training during handover processes. Consumers indicated staff are knowledgeable and familiar with their care.

The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these Standards. Staff have access to online training, including mandatory training modules and completion of mandatory training is monitored to ensure compliance, and feedback on training provided is sought.

The service has a staff performance framework which ensures staff performance is regularly assessed, monitored and reviewed. Staff performance appraisals are conducted at three and six months during the probationary period then annually thereafter. Where poor staff performance had been identified, documentation demonstrated performance management processes had been implemented to address the issues raised.

Based on the Assessment Team’s report, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Compliant with all Requirements 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) Compliant

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

### 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) Compliant

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

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

Requirement (3)(d) in this Standard was found Non-compliant following an Assessment Contact – Site undertaken from 13 July 2021 to 14 July 2021 where risk management systems were found to not be effective in managing high impact or high prevalence risks associated with the care of consumers. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified.

At the Site Audit, the Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 8 Organisational governance not met. The Assessment Team found the organisation was unable to demonstrate:

* effective governance systems relating to regulatory compliance; and
* effective use of an incident management system to manage and prevent incidents.

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

In relation to Requirements (3)(a), (3)(b) and (3)(e) in this Standard, the Assessment Team found overall, sampled consumers considered that the organisation is well run and that they can partner in improving the delivery of care and services.

Consumers are engaged in the development, delivery and evaluation of care and services through meeting forums, surveys, care review processes and feedback processes. Resident meeting minutes demonstrated consumers have input and provide feedback into care and service delivery. The service has had significant changes to management personnel in the past 12 months, and management described how these changes had been communicated to consumers and representatives on an ongoing basis.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The organisation is governed by a Board who are supported by a Chief executive officer. Service management and the Chief executive officer are accountable to the Board to ensure the service is demonstrating and living up to its mission, vision and values. The Board monitors against the Quality Standards using audits, reporting on national quality indicator program, including benchmarking against national data, and constantly considers risk and strategies used to minimise risk for all areas, both operational and to individual consumers.

The organisation has policies and procedures to guide staff practice in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. While consumers subject to restrictive practices had not been correctly identified, efforts made to minimise use of restrictive practices were demonstrated.

Based on the evidence documented above, I find St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, Compliant with Requirements (3)(a), (3)(b) and (3)(e) 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) Non-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.*

The organisation demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. However, the Assessment Team were not satisfied effective governance systems relating to regulatory compliance were demonstrated. The Assessment Team’s report provided the following evidence relevant to my finding:

* The Restrictive practices minimisation and management procedure, dated January 2022, did not reflect legislative changes introduced on 1 July 2021 and   
  1 September 2021 relating to restrictive practices and Behaviour support plans and related requirements.
* The service advised no consumer is considered chemically restrained as they are all prescribed medication for the treatment of diagnosed conditions.
* The Psychotropic self-assessment tool identified 15 consumers prescribed as required psychotropic medications for diagnosed conditions which are not recognised medical diagnoses under the World Health Organisation’s International Classification of Diseases.
* The tool also indicated 14 consumers are prescribed as required psychotropic medication for anxiety, however, not all had corresponding diagnoses.
* Four clinical staff advised any medication administered for the intention of altering mood or behaviour is considered a chemical restraint and did consider consumers to be subject to chemical restrictive practices.
* Whilst clinical and care staff could describe the requirement to implement non-pharmacological strategies and use medications, including psychotropic medications as a last resort, none of the were familiar with Behaviour support plan terminology.

The provider acknowledged the Assessment Team’s recommendation of not met, and indicates the service continues to address and correct these requirements. The response included commentary and documentation demonstrating corrective actions initiated and ongoing. Additionally, the response included a Plan for continuous improvement directly addressing deficits identified by the Assessment Team, as well as planned actions and outcomes. The provider’s response included, but was not limited to, Behaviour support plans have been reviewed and a new plan implemented for restrictive practices; and Behaviour support plans for consumers subject to restrictive practices are currently being updated.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation’s regulatory compliance governance systems were not effective to ensure changes to legislation are identified.

In coming to my finding, I have considered that changes to legislation relating to restrictive practices, which came into effect on 1 July 2021 and 1 September 2021, have not been identified or implemented. Management and staff did not demonstrate an understanding of restrictive practices, specifically chemical restraint or Behaviour support plans. The provider’s response also indicates no education or training was provided by previous management in relation to the legislative changes and there is no indication the legislation was communicated by the clinical team.

For the reasons detailed above, St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

**Requirement 8(3)(d) Non-compliant**

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

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

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks and supporting consumers to live the best life they can. However, the Assessment Team were not satisfied the service demonstrated effective use of an incident management system to manage and prevent incidents. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two complaints had not been identified as potential incidents requiring reporting to the Serious Incident Response Scheme (SIRS), although one was still under investigation at time of the Site Audit.
* A complaint was lodged in May 2022 by representative, reporting missing items. An incident form was not completed, and although management acknowledged there had been consideration to lodge a report through SIRS, they could not explain whether the matter would be reported to Police or the decision-making process to guide staff on when to report to the Police.
* A complaint was lodged in May 2022 on behalf of a consumer, relating to a staff member’s behaviour towards the consumer. The employee’s personnel file did not reflect any discussion or feedback provided about the complaint. The response to the complaint did not include any information on investigation of the report, and management could not explain why this was not reported as an incident, or how it was determined to not meet the reporting criteria for SIRS.
* Another incident was not captured under the incident management system. The matter was appropriately escalated but not captured as an incident through the incident management system despite management identifying the significant risk to all consumers.

The service was found Non-compliant with Requirement (3)(d) following an Assessment Contact undertaken from 13 July 2021 to 14 July 2021, where it was found the service’s risk management systems were not effective in managing high impact or high prevalence risks associated with the care of consumers. Specifically, the service failed to identify inadequacies in documentation and inconsistencies with implementation of the service’s policies, resulting in the ineffective management of diabetes, falls and wounds. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, implementing a framework for clinical risk, ensuring documentation is reviewed by nursing staff to identify concerns; and ongoing education for Registered nurses on leadership and management, with increased oversight by clinical management in the interim.

The provider acknowledged the Assessment Team’s recommendation of not met, and indicates the service continues to address and correct these requirements. The response included commentary and documentation demonstrating corrective actions initiated and ongoing. Additionally, the response included a Plan for continuous improvement directly addressing deficits identified by the Assessment Team, as well as planned actions and outcomes. The provider’s response included, but was not limited to, completion of incident report for SIRS and reviewed procedures and flowcharts; incident policy reviewed to ensure it meets SIRS criteria; and organised training for the senior management team on incident reporting and investigation.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, risk management systems and processes in relation to managing and preventing incidents, including the use of an incident management system were not effectively demonstrated.

In coming to my finding, I have considered that on receipt of the complaints, the organisation has not appropriately responded to, considered and/or undertaken the appropriate notifications for the complaints highlighted. Two of the complaints had not been reported through the incident management system, including one which highlighted significant risk to consumers. I have also considered the evidence presented indicates knowledge deficits relating to reporting requirements under SIRS.

I have also considered evidence highlighted in Standard 2 Ongoing assessment and planning with consumers Requirement (3)(a) and Standard 3 Personal care and clinical care Requirement (3)(a) indicating staff have not consistently applied incident reporting and escalation processes. Not all consumer incidents relating to personal and/or clinical care are being documented, escalated or reported. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement, or risks to consumers’ health and well-being are being minimised and/or eliminated.

For the reasons detailed above, St Paul’s Lutheran Homes Hahndorf, in relation to St Paul’s Lutheran Hostel, to be Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

**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.

**Standard 2 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to:
* Undertake initial assessments in line with the service’s processes;
* Initiate assessments and develop and/or update care plans in response to changes in consumers’ health and well-being.
* Ensure consumer care plans are personalised and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment and care planning are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment and care planning review.

**Standard 3 Requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* Provide appropriate care relating to wounds, restrictive practices, behaviours, and falls.
* Review and undertake wound treatments in line with the service’s processes, ensuring wound measurements and staging or classification are routinely documented.
* Undertake post falls assessment and monitoring in line with the service’s processes.
* Develop and/or implement appropriate behaviour management strategies and monitor effectiveness of strategies.
* Identify and implement changes to care and service needs, including Medical officer and/or external health provider recommendations; and
* Review monitoring charts, initiate appropriate assessments, develop management plans and monitor effectiveness of management plans, including in relation to behaviour management.
* Ensure policies, procedures and guidelines in relation to managing high impact or high prevalence clinical risks, including behaviour management, wound care, restrictive practices and falls management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to managing high impact or high prevalence clinical risks, including behaviour management, wound care, restrictive practices and falls management.

**Standard 8 Requirements (3)(c) and (3)(d)**

* Review the organisation’s governance systems in relation to regulatory compliance, specifically identification and implementation of legislative changes.
* Review the organisation’s risk management processes in relation to managing and preventing incidents.