Performance

Report

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| Name of service: | St Raphaels Home For The Aged |
| Service address: | 2 Franciscan Avenue LOCKLEYS SA 5032 |
| Commission ID: | 6107 |
| Approved provider: | Franciscan Sisters of the Heart of Jesus (South Australia) Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 March 2023 |
| Performance report date: | 1 May 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 St Raphaels Home For The Aged (**the service**) has been prepared by J Renna, 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 on 19 April 2023; and
* the performance report dated 19 October 2022 in relation to the Site Audit undertaken from 30 August 2022 to 2 September 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 5** Organisation’s service environment | **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.

* Ensure safeguards are in place to minimise harm to consumers whilst renovations are being undertaken.
* Ensure the service environment enables free movement, both indoors and outdoors.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(e) | 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. | Compliant |

Findings

Requirements (3)(b) and (3)(e) were found non-compliant following a Site Audit undertaken from 30 August 2022 to 2 September 2022, as the service was unable to demonstrate:

* high impact or high prevalence risks associated with the care of each consumer were effectively managed, specifically in relation to use of restrictive practices and management of pressure injuries; and
* information about the consumer’s condition, needs and preferences was documented and communicated accurately to inform the delivery of safe and effective care.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, obtained informed consent and updated behaviour support plans for consumers subject to restraint, updated policies and procedures, and provided staff education and training.

The Assessment Team found these improvements were effective and recommended Requirements (3)(b) and (3)(e) met.

In relation to Requirement (3)(b), the Assessment Team’s report shows consumers and representatives were satisfied with the care and services provided. Consumers and representatives said, and care documentation showed, the service identified risks in relation to consumers’ care, including falls, diabetes, pain, wounds and skin integrity, and mitigation strategies had been implemented in response to risks identified. Care documentation showed risks are regularly monitored through progress note reviews, clinical audits and care plan reviews.

In relation to Requirement (3)(e), the Assessment Team’s report shows consumers’ condition, needs, goals and preferences were known to those involved in their care, and communication systems used to transfer information included accurate information. For sampled consumers, care documentation showed timely communication of changes in care and service delivery, including in relation to changed dietary needs, commencement of palliative care and change in mobility/physical function.

The provider’s response did not include any reference to the Assessment Team’s findings in relation to Requirements (3)(b) and (3)(e).

Based on the information summarised above, I find the service compliant with Requirements (3)(b) and (3)(e) in Standard 3 Personal care and clinical care.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 30 August 2022 to 2 September 2022, as the service was unable to demonstrate outdoor areas were easily accessible, clean and tidy, and free from safety hazards. Furthermore, chemicals were not observed to be stored in a safe manner.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, completed a cleaning audit and placed chemicals in locked storage, added an environmental audit to inform preventative maintenance, removed old and/or unsafe furniture from outdoor areas, and commenced renovations to improve footpaths and the kitchen.

At the Assessment Contact undertaken on 30 March 2023, the Assessment Team found continued deficits relating to accessibility and safety of outdoor areas. The Assessment Team recommended Requirement (3)(b) not met and provided the following evidence relevant to my finding:

* Three doors leading to outdoor areas were locked. While the front door had keypad access and the code was visible, the keypad was located behind a curtain.
* The service is currently undergoing major renovations to refurbish the kitchen, extend the dining room and landscape outdoor areas. The following hazards were observed:
  + The outside area had a tarpaulin sheet installed from the roof; however, consumers can still climb under the sheet and access areas of the grounds that are being renovated.
  + Uneven ground and pavers, posing a trip hazard.
  + No safeguards were in place to prevent consumers from falling into an unfilled water fountain that had uneven ground around it.
  + Gas cylinders outside the temporary kitchen were not restrained from falling.
* Management said they discussed the locking of doors with consumers who are cognitive, and they said they knew how to get outside and were happy with the doors being locked.
* Two representatives said they can take their family members outside if needed by using the keypad near the front door. One consumer said staff will take them outside if needed, as they cannot walk by themselves.
* Two staff said garden paths are not safe, so they will take consumers outside.

The provider acknowledged improvements to be made in relation to the organisation’s service environment. The provider’s response states they are committed to improving the service environment and safety of consumers, and upgrades to the outdoor environment will commence early May 2023.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates the organisation’s service environment is not safe and well maintained, or that it enables consumers to move freely, both indoors and outdoors.

I acknowledge the service has scheduled renovations to address safety hazards identified by the Assessment Team, however, I have considered that the service has not implemented any measures to ensure the safety of consumers who use these areas in the interim. Furthermore, while management said cognitive consumers were not dissatisfied that doors were locked, the intent of the Requirement expects the service environment to promote free movement of all consumers, not only those who are cognitive.

Based on the information summarised above, I find the service is non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | 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. | Compliant |
| Requirement 8(3)(e) | 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. | Compliant |

Findings

Requirements (3)(c) and (3)(e) were found non-compliant following a Site Audit undertaken from 30 August 2022 to 2 September 2022, as the service was unable to demonstrate:

* effective organisation wide governance systems relating to information management and workforce governance; and
* an effective clinical governance framework in relation to minimising the use of restraint.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, updated policies and procedures, training and education to both staff and members of the Board, and developed a restrictive practices flowchart.

The Assessment Team found these improvements were effective and recommended Requirements (3)(c) and (3)(e) met.

In relation to Requirement (3)(c), the Assessment Team’s report shows the organisation has an overarching governance framework, including monitoring systems, assigned delegations and accountabilities, and policies and procedures. Information systems and processes are in place to ensure staff and management have sufficient information relevant to their role, including consumer information and procedures. The service has processes to identify areas for improvement, including through resident and relative meetings, surveys and complaints. Financial reports are reviewed annually and processes are in place to make purchases as required, such as equipment and furniture. Workforce governance processes ensure all staff have relevant qualifications and knowledge to effectively perform their role, including pre-employment screening, and performance management and appraisal processes. The organisation has memberships with peak bodies to monitor changes to regulatory obligations. Feedback and complaints processes are in place and are managed at site level.

In relation to Requirement (3)(e), the Assessment Team’s report shows the organisation has a clinical governance framework relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. The service maintains a log of all infections, including type and treatment, which is monitored by a Medication Advisory Committee and the Director of Residential Care Services. Care documentation showed regular review of restraint and processes are in place to assess associated risk and obtain informed consent. Staff were knowledgeable of antimicrobial stewardship and legislative requirements relating to the use of restraint, and provided examples of how they practice open disclosure.

The provider’s response did not include any reference to the Assessment Team’s findings in relation to Requirements (3)(c) and (3)(e).

Based on the information summarised above, I find the service compliant with Requirements (3)(c) and (3)(e) in Standard 8 Organisational governance.

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)