Star of the Sea Home for the Aged

Performance Report

15 Elizabeth Street   
WALLAROO SA 5556  
Phone number: 08 8823 0000

**Commission ID:** 6028

**Provider name:** The Catholic Diocese of Port Pirie Inc

**Site Audit date:** 28 June 2022 to 1 July 2022

**Date of Performance Report:** 31 August 2022

# Performance report prepared by

Alla Kasyan, 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) | 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** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-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** | **Non-compliant** |
| Requirement 7(3)(a) | Non-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) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-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 staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 2 August 2022.

# 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 recommended Requirement (3)(d) in this Standard as not met. The Assessment Team found the service was unable to demonstrate each consumer is supported to take risks to enable them to live the best life they can.

Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view from the Assessment Team and have found Requirement (3)(d) in this Standard to be Compliant. I have provided reasons for my findings in the specific Requirement below.

In relation to Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in this Standard, the Assessment Team found overall, sampled consumers consider 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. Specific comments and feedback from consumers include:

* Consumers said staff were kind, caring, respectful and understood them and their needs.
* Consumers confirmed staff value their culture and values, and enable them to feel valued, and safe.
* Consumers said staff welcomed their visitors and supported them to keep in touch with family when they couldn’t visit. They also said they receive information in a variety of ways, including through consumer meetings, newsletters, menus, lifestyle calendars and directly from staff and management.
* Consumers stated they were satisfied staff ensure their privacy is respected and their personal information is kept confidential.

Staff interviewed were familiar with the likes, background and history of sampled consumers and knew what they liked, such as how they liked their room cleaned and what they like to reminisce about. Staff were able to demonstrate they are familiar with consumers’ backgrounds, cultures, and how their individual preferences influence the lifestyle activity calendar. Management described how a culture of care framework is used to guide staff in the provision of culturally safe care and services.

Staff described occasions and events where culturally appropriate foods are prepared for the consumers and special meals are served for consumers with a taste for ethnic food. Staff advised consumers assist with preparing foods form different cultures. Staff described how consumers are supported in a decision-making process.

Care planning documentation reflected sampled consumers’ decisions and choices about their care such as preferred activities or religious services to be invited to and specific cultural needs. Care planning documents reflected the diversity of consumers, their background work history, family history, culture, interests, likes, dislikes, and preferences.

The Assessment Team observed various information available throughout the service to help and inform consumers in making decisions about their care. They also observed staff acting in a respectful manner in relation to consumers’ privacy.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with 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.*

The Assessment Team found the service was unable to demonstrate each consumer is supported to take risks to enable them to live the best life they can. The Assessment Team provided the following information and evidence relevant to their recommendation:

* One consumer has had several choking episodes since their admission three months ago. However, no interim measures or strategies were implemented nor documented in the consumer’s care plan to prevent choking episodes. The consumer confirmed no swallowing assessment had occurred. The consumer was reviewed by a speech pathologist on the last day of the site audit following the feedback provided to management by the Assessment Team.
* The second consumer has had multiple falls when walking without staff supervision which is not in line with the consumer’s assessed mobility needs documented in the consumer’s care plan. There was no documented evidence to demonstrate new strategies were implemented or trialled after each fall to prevent falls.
* Two consumer rooms had retractable screens installed over doorways. Management informed the retractable screens were used to stop consumers who wander from entering other consumers’ rooms.
* Dignity of Risk Consultation Records were completed for two consumers where the risk-taking activity identified was a use of retractable screen to prevent entry of consumers who wander.
* One consumer who had retractable screen installed over their doorway advised they were offered the screen to stop consumers from entering their room. The consumer could not recall having a discussion about risks to them when the screen is in place. Whilst the consumer advised they wanted to keep the screen in place because they did not want other people coming into their room, they advised they could not retract the screen independently and need to use call bell to let the staff know they need help with the screen.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* The consumer who had choking episodes has been reassessed by the speech therapist and has been commenced on a modified diet and fluids in consultation with the consumer and their representative. This occurred on the last day of the site audit.
* The consumer who had multiple falls has been reassessed by the physiotherapist and the consumer’s care plan has been reviewed and evaluated.
* Consumers who have screens in place have been consulted around either the removal of the screen or a consent to use the screen at the discretion of the consumer. The service has consulted with the 2 consumers who have screens installed. Evidence of consultation was included in the provider’s response and shows that both consumers chose to leave screens in place.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

In coming to my finding, I have considered that the evidence presented in this Requirement does not indicate consumers are not supported to take risks to live the best life they can. Evidence presented in this Requirement is related to deficits/gaps in Standard 2 Requirement (3)(a) and Standard 8 Requirement (3)(e) which I found to be Non-compliant.

This requirement is about how the organisation respects a consumer’s wishes and preferences relating to the risks they choose to take. Dignity of risk refers to the legal right of every person to make choices and take risks in order to have better quality of life.

The evidence presented in the Assessment Team report and the provider’s response does not show deficits in the service’s practices and processes to support the consumer who had choking episodes with risks they wished to take to have a better quality life. The evidence presented to me shows the consumer had swallowing difficulties and, as a result, they experienced choking/coughing episodes. Choking episodes were not related to the choices the consumer was making and the risks the consumer wanted to take, rather to the fact that the consumer had swallowing deficits and required assessment by the relevant health professional.

The evidence presented in relation to the second consumer, who had multiple falls, does not show this consumer was not supported when they wished to mobilise without staff assistance and supervision. The evidence presented in the Assessment Team’s report and the provider’s response shows the consumer was known to have a moderate to severe mixed type dementia syndrome and was unable to make informed decisions due to severe cognitive impairment. The consumer was known to have high falls risk, lack of insight into their own safety and were impulsive.

Whilst the consumer has had multiple falls when they tried to mobilise without staff assistance, this does not indicate the service did not let the consumer take risks when the consumer wished to mobilise without staff assistance. Not responding to the consumer’s attempts to mobilise in a timely manner to prevent serious injuries from occurring is related to management of high impact/high prevalence risk of falls risks which I considered when making a decision in relation to Standard 3 Requirement (3)(b).

The evidence presented to me shows, two consumers who had retractable screens over the doorways in place, have been offered them by the service to deter wandering consumers from entering the consumers’ bedrooms. Installation of the screens is not a risk-taking activity the consumers wished to take to have better quality of life. The main purpose of the screens was to restrict a consumer with wandering behaviours access to other consumers’ rooms which could have a potential unanticipated effect on the rights of those consumers due to its restricting nature. Therefore, I considered this evidence in Standard 3 Requirement (3)(b) in relation to management of high impact risks associated with consumers’ behaviours of concern and in Standard 8 Requirement (3)( e) in relation to the provider’s obligations to minimise the use of restraint.

I have also considered evidence presented in the Assessment Team’s report which shows consumers are generally supported to take risks to live the best life they can. For example:

* Consumers confirmed they are able to live the life they want and felt supported by the service to achieve their goals.
* Consumers said they have a beer or wine with their meals as per their preferences.
* Staff showed their awareness of what dignity of risk means in practice. Staff said they encourage consumers to be as independent as possible and support them to take risks if they choose to do so. They gave an example of a consumer who chooses to leave the service on their own on a gopher.
* The service has policies and procedures that guide staff in relation to this requirement.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

### 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)(e) in this Standard as not met. The Assessment Team found the service was unable to demonstrate care and services are reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view from the Assessment Team in relation to Requirement (3)(e) and have found this Requirement to be Compliant. However, I have found Requirement (3)(a) to be Non-compliant. I have provided reasons for both findings in the specific Requirements below.

In relation to Requirements (3)(b), (3)(c) and (3)(d) in this Standard, the Assessment Team found overall, sampled consumers consider they feel like partners in the ongoing assessment and planning of their care and services. Specific comments and feedback from consumers include:

* Consumers and representatives confirmed the service has discussed their care plan with them and they are informed of changes. Two consumers interviewed confirmed palliative care and end of life wishes are discussed when entering the service and through care plan reviews.
* Consumers and representatives interviewed said they were satisfied with the level of communication by staff in relation to the outcomes of assessment and planning. Two consumers confirmed they have been involved in discussions with clinical staff and their representative on multiple occasions and felt they have been consulted and included in all aspects of their care planning.
* One consumer’s representative said the service contacts them regularly whenever their consumer’s care needs may need to be reviewed.

Consumer files reviewed confirmed assessments and planning identifies and addresses the consumer’s current needs, goals and preferences completed in consultation with the consumer and/or representative on entry and when changes occur. Care documentation included a palliative care assessment and identified consumer’s end of life preferences in line with their advanced care directives. Assessments and care plans show input from other allied health professionals and external specialists to ensure all aspects of consumer’s care needs are documented.

Staff were able to describe the assessment process and how this influences the provision of care, and consumer’s and representatives confirmed they are informed and involved in the assessment and planning process.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, 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 recommended the service met this Requirement. However, based on the evidence in Standard 1 Requirement (3)(d), Standard 2 Requirement (3)(e) and Standard 8 Requirement (3)(e), I find this Requirement Non-compliant. The Assessment Team provided the following information and evidence relevant to my finding for this Requirement:

* Consumer A was known to have moderate to severe dementia and was wandering and entering other consumers’ rooms daily. Strategies listed in Consumer A’s care plan were generic in nature and did not address the consumer’s wandering into other consumer’s rooms.
* The service did not complete a comprehensive assessment of Consumer A’s behaviours of concerns. Staff reported Consumer A displays ongoing daily behaviours of concerns. However, behaviour chartings were not completed to ensure all necessary information (e.g., triggers, behaviour description and consequence, frequency, timing and presentation) is captured for effective analysis of behaviours.
* Assessment of risk of choking and strategies to minimise the risk had not been undertaken for Consumer B following a choking incident. Information related to the risk of choking was not captured in the consumer’s care plan to ensure all staff knew of the potential risk and how to minimise the risk.
* Assessment of environmental restrictive practices had not been undertaken for 2 consumers following a change of environment when retractable screen doors were installed over the consumers’ doorways. Behaviours support plans were not completed where restrictive practices were in place.

The Approved Provider’s response did not directly respond to this Requirement, however, did provide evidence acknowledging the deficits in assessment and planning as identified by the Assessment Team. The response included an action plan, detailing improvements to address the deficits, including review and reassessment of all consumers identified in the report and ongoing training for staff in relation to assessment.

In coming to my finding, I have considered the service had undertaken appropriate actions to address the deficits in the assessments and care plans of consumers identified by the Assessment Team. However, at the time of the site audit the service did not have effective processes to ensure each consumer had appropriate assessments completed to inform and develop the strategies in each consumer’s care plan. Behaviour assessments were not consistently completed or used to evaluate consumers’ behaviours of concern and behaviour management strategies to inform the care plans following changes in consumers’ needs. Assessment of environmental restrictive practices were not undertaken following a change of environment and behaviours support plans were not completed where restrictive practices were in place. The service’s monitoring processes were not effective at identifying the deficits in the assessment and planning of consumers care as identified by the Assessment Team.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, 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.*

The Assessment Team found the service was unable to demonstrate care and services are reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team provided the following information and evidence relevant to their recommendation:

* Consumer A has ongoing wandering intrusive behaviours which have impacted on the personal space and mental health of other consumers. Whilst the consumer’s care plan included information about their wandering behaviours triggered by missing their family member and relevant interventions, there was no mentioning of Consumer A’s ongoing intrusive behaviour of removing other consumers’ belongings when entering those consumers rooms uninvited.
* Staff and consumers reported Consumer A wanders into other consumer’s rooms on a daily basis and at times, multiple times per day. However, documentation shows these behaviours are not captured to enable accurate assessment of the consumer’s needs, triggers for these behaviours and interventions.
* Consumer A has had 13 falls between February and June 2022, with 11 falls being unwitnessed. Whilst Consumer A’s care plan was reviewed after each fall, falls risk minimisation strategies remained unchanged.
* Consumer B had a choking episode 5 days prior to the site audit which was recorded in the progress notes. Progress notes entries record the consumer was choking during lunch time and then told staff they sometimes choke on fluids especially when they get stressed.
* Appropriate actions have been taken immediately following the choking incident which included instructing the consumer to sit upright and sending a referral to speech pathologist. However, the consumer remained on the same food texture and fluid thickness despite this choking incident.
* Clinical staff advised they were awaiting speech pathologist review during their monthly scheduled visits. Clinical staff advised they did not make changes in the texture of the consumer’s diet when asked if this was done as an interim measure.
* Consumer B reported they have had several choking episodes and were told by staff that they will be tested. However, this did not happen.
* Consumer B was assessed by a speech pathologist on day three of the site audit, and the consumer’s care plan was updated.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* Care plan of Consumer A has been reviewed and updated to capture missing information such as Consumer A’s wandering behaviours when they enter other consumers’ rooms and interfere with the consumers’ belongings.
* Change to shift times on roster to increase staff presence in the wing where Consumer A resides have been implemented as a new falls preventative strategy and to ensure frequent visual checks occur.
* Consumer A has been referred to and reviewed by an external service provider specialising in providing advice in relation to improving outcomes for people living with dementia.
* Consumer B’s care plan has been updated following the speech pathologist’s assessment and recommendation to downgrade the consumer’s diet to ensure safe swallowing that is compromised by fatigue and health decline. Consumer B’s family have been contacted by phone and consulted regarding ongoing care needs and dietary changes including recent changes in both cognitive status and physical abilities.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

* In coming to finding, I considered evidence presented in the Assessment Team’s report in this Requirement and Requirements (3)(a) and (3)(b) in Standard 2. The Assessment Team found care plans for the sampled consumers have been reviewed and updated at regular intervals, at least every 6 months, in line with the service’s policy, and assessments and planning identified and addressed the consumer’s needs, goals and preferences and these were noted to be current.
* I acknowledge, Consumer A’s care plan was not comprehensive and did not include specific details about particular consumer behaviour which is where the consumer enters other consumers’ rooms and interferes with the consumers’ belongings. However, I consider the core deficiency of assessment and planning process is related to Standard 2 Requirement (3)(a).
* Evidence presented in the Assessment Team’s report shows Consumer A’s wandering was causing distress to other consumers. It is expected the service takes all reasonable steps to minimise impact of behaviours of concern on other consumers. I have considered this information in Requirement (3)(b) in Standard 3 which I found to be Non-compliant.
* Whilst the Assessment Team noted that Consumer A’s strategies remained the same following falls, this is not indicative of care and services for this consumer not being reviewed for effectiveness as there is no evidence a review did not occur. I consider Consumer A’s care plan indicated the consumer was high falls risk, and falls preventative strategies were both universal and tailored to the consumer’s needs and remained the same because were appropriate to the consumer.
* It is not intent of this requirement to ensure the service trials new strategies after each fall. I consider Consumer A was reviewed by physiotherapist following the site audit who was satisfied with existing falls preventative strategies in place and advised no changes are required to be made as the care plan was current. It appears to me that Consumer A’s care plan included strategies that would have been effective if applied successfully. I have considered deficits around successful implementation of these strategies in Standard 3 Requirement (3)(b) which I found to be Non-compliant.
* I consider Consumer B’s care and services were reviewed for effectiveness following a choking incident. I considered the incident was documented in the progress notes and appropriate actions followed. Clinical staff sent a referral to a speech pathologist and encouraged the consumer to sit upright.
* I accept, Consumer B’s care plan was not updated following the incident of choking on fluids, and I have considered this information in coming to my finding in Requirement (3)(a) in this Standard.
* In relation to clinical staff not making changes in the texture of the consumer’s diet as an interim measure before speech pathologist review, I’m not convinced it was necessary or in line with the organisation’s policies and procedures.
* Three months into the entry to the service, there was one documented incident of the consumer B’s choking when consuming fluids. I accept, Consumer B reported to the Assessment Team they had more than one episode of choking/coughing during meal/fluids consumption. However, this information was not corroborated by documentation or interviews with staff or management.
* Consumer B was referred to the speech pathologist on the very same day when the coughing incident took place. There is no evidence the consumer had further incidents between that day and when the site audit commenced.
* It is unreasonable to suggest that the service failed to review Consumer B’s care and services following the choking incident on a base that the consumer’s diet was not downgraded prior to the site audit.
* I acknowledge, a nurse sent a referral to the speech pathologist because they identified the consumer might have had some underlying health problems leading to swallowing issues.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# 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 one of the seven specific requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirement (3)(b) in this Standard as not met. The Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of three consumers specifically in relation to management of risk of falls, behaviours of one consumer impacting health and well-being of other consumers and choking risks. The Approved Provider submitted a response to the Assessment Team’s report.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with Requirement (3)(b) in this Standard. I have provided reasons for my decision in the specific Requirement below.

In relation to Requirements (3)(a), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, the Assessment Team found overall, consumers consider they receive personal care and clinical care that is safe and right for them. Specific examples provided by consumers included:

* Consumers and representatives said they are satisfied consumers are receiving the care they need that is right for them. This included management of wounds and pain.
* One consumer said they are satisfied with the way staff manage their pain. They said staff consult with them and always ask if the current strategies are effective.
* One consumer said when a dietitian made changes to their diet, staff in the kitchen were informed and they are satisfied they receive the correct meals.

Staff provided examples of how they provide care and ensure services are delivered in a safe and effective manner by referring to a consumer’s care plan and policies and procedures. Documentation including progress notes, referrals and medication charts demonstrates the service has robust systems in place to ensure consumer’s end of life needs and preferences are met.

Staff described how they monitor and respond to consumers’ decline in their swallow ability, mental health, cognitive or physical function and provided examples of timely actions taken when consumers had unintentional weight loss, mental health changes and pressure injuries.

Documentation shows information is communicated effectively within the service and with others where responsibility is shared. Staff are informed of any changes to consumers’ health, condition and needs regularly through their handover process and alerts on the service’s computerised documentation system. Referrals are completed to internal and external allied health professionals and specialists in a timely manner. Staff described how referrals are completed and how the service communicates any changes or recommendations to staff, consumers and representatives.

The service has implemented changes to their infection control strategies to include a COVID-19 infection management plan. Staff reported they have a clear understanding of infection control and antimicrobial stewardship principles and are working with medical officers to promote appropriate antibiotic prescribing and use of antibiotics.

Based on the Assessment Team’s report, Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirements (3)(a), (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) 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.*

### 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 found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of three consumers specifically in relation to management of risks associated with falls, behaviours of one consumer impacting health and well-being of other consumers and choking risks.

The Assessment Team provided the following information and evidence relevant to my finding:

* Consumer A has ongoing wandering and intrusive behaviours which have been causing distress and anxiety for other consumers. Consumer A goes into other consumers’ rooms uninvited and this issue has been ongoing.
* Three consumers reported to the Assessment Team they were not satisfied with how the service managed the behaviours of Consumer A and provided examples of how their well-being has been impacted:
* Consumer A did not receive supervision in line with their assessed needs to manage their risk of falls. In the last 6 months, Consumer A has had 11 of the 13 total falls occurring when the consumer was mobilising without staff supervision.
* Consumer A was observed wandering unaccompanied on all four days of the Site Audit without staff supervision.
* Documentation showed staff did not attend neurological observations in line with the service’s policies and procedures to effectively manage risks associated with actual or potential head injury.
* Consumer B’s care plan was not updated to reflect risk of choking following a choking episode witnessed by staff.

The Approved Provider’s submitted response in relation to this requirement and provided evidence acknowledging the deficits in the management of falls and behaviours. The Approved Provider has commenced an action plan to address the gaps identified in the Assessment Team’s report and have provided further information in relation to Consumer A. This information and improvement actions include, but are not limited to:

* Following the site audit, the service sent a referral to external service providers to review Consumer A in relation to ongoing behaviours of concerns going into other consumers’ rooms. Advice on both pharmacological and non-pharmacological interventions have been provided by the service providers and have been incorporated into Consumer A’s care plan.
* Training to clinical staff in relation to neurological observations is planned to be delivered in August 2022. The service is planning to introduce weekly follow up of falls to ensure risks and effectiveness of interventions are addressed timely and effectively.

I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified in the Assessment Team’s report. However, at the time of the Site Audit, I find the service did not demonstrate they effectively managed each consumer’s high impact or high prevalence risk associated with their care. Three consumers reported to have been impacted by ineffective management of high impact/high prevalence risks associated with the behavioural and psychological symptoms of dementia of Consumer A. Risks of choking of one consumer have not been managed effectively because no strategies have been put in place to reduce the known risk of choking after the witnessed incident. Neurological observations of consumers post fall were not attended to in line with the organisation’s policies and procedures to ensure risks associated with head injury are identified and acted upon in a timely manner.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, 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 recommended Requirement (3)(c) in this Standard as not met. The Assessment Team found the service was unable to demonstrate each consumer is supported do the things of interest to them.

Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view from the Assessment Team and have found Requirement (3)(c) in this Standard to be Compliant. I have provided reasons for my findings in the specific Requirement below.

In relation to Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, the Assessment Team found overall, sampled consumers consider 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. Specific comments and feedback from consumers include:

* Consumers and representatives confirmed staff support them to do the things that are socially, spiritually, and emotionally important to them.
* Consumers described how they can leave the service to go for walks, leave to spend time with families and friends and go out to the community for shopping and coffee.
* Two consumers said they regularly attend church services held at the service.
* One consumer said there is a hair salon and nail salon at the service and they enjoy these services.
* Consumers interviewed said if they do not like what is on the menu; catering staff offer them alternatives such as sandwiches or salads. If they feel hungry in-between meals staff can bring them snack foods or sandwiches.
* Consumers said that a tray meal service is provided if they prefer to dine in their rooms.

Documentation showed the service’s assessment process identifies consumers’ needs, goals and preferences, and this information is used to optimise their health and well-being, including referrals to community organisations.

Staff demonstrated their understanding of consumers’ needs, preferences, life experiences and interests. Documentation and interviews with lifestyle staff demonstrated an activity schedule is reviewed regularly, includes activities of interest to consumers and reflects consumers’ diversity, needs and preferences.

Catering and care staff described how they ensure meals are varied and of suitable quality and quantity for consumers. Kitchen staff described how they actively seek feedback on the consumer meal service by attending the dining rooms to discuss the food choices. Documentation showed the menu is rotated on an 8-week cycle and consists of a summer and winter menu. The Assessment Team observed the kitchen to be clean, tidy and staff were observed applying food safety processes when serving food.

Equipment used by lifestyle staff was observed to be clean and well maintained and staff confirmed they have access to equipment to support consumers’ needs.

Based on the Assessment Team’s report, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, 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.*

### The Assessment Team found whilst the service demonstrated services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment and have social and personal relationships, two consumers were not supported to do the things of interest to them.

### The Assessment Team provided the following information and evidence relevant to their recommendation:

* Consumer A does not receive adequate socialisation and engagement to prevent their ongoing wandering and intrusive behaviours. Whilst the activities plan lists a range of activities Consumer A enjoys, these are not incorporated into their care plan. Activity attendance sheet confirmed the consumer was not engaging in activities of their interest every day. Therapy staff advised they try to attend to as many consumers as they can during their shift. However, it is not possible to attend to Consumer A every day. Three staff confirmed they do not have sufficient time to engage in social activities with Consumer A.
* Consumer B said they would like to do some woodwork and being able to do drafting. However, they have not been able to do that as they need a large table and are not allowed to use a saw. After feedback was provided, management said they were looking into this with maintenance to obtain a larger tabletop for the consumer and also for woodworking activities.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* Consumer A was referred to an external service provider and to the mental health specialist for review and advice. As a result, pharmacological and non-pharmacological dementia support strategies and interventions recommended by the specialists have been incorporated into Consumer A’s care plan and were being trialled. Effectiveness of the interventions will be reviewed in September 2022.
* Consumer B’s care plan have been updated to reflect their goals around being able to do drafting and woodwork. The Approved Provider confirmed the lifestyle team is investigating available opportunities to facilitate these activities.
* The service expressed commitment to improve information gathering processes to ensure all information regarding consumer interests is accurately gathered during the admission process. Corresponding assessment form has been updated and will be evaluated for effectiveness in October 2022.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

* I have considered evidence in the Assessment Team’s report where observations and interviews with consumers confirmed consumers are supported to maintain social and personal relationships and participate in their community within and outside the organisation’s service environment.
* I have also considered evidence presented in the Assessment Team’s report in this Standard in Requirement 4 (3)(a) where consumers interviewed stated they can choose what activities they wish to participate in and staff respect their wishes if the consumers decline to participate; one-on-one visits are tailored to consumers’ needs and preferences, with lifestyle staff or volunteers visiting consumers and engaging in activities of consumers’ interests such as arts and crafts or walks in the garden; the service’s lifestyle activities schedule is regularly reviewed and revised in line with consumer’s feedback and the observations of consumers participated in a range of activities throughout the four-day Site Audit.
* I accept, Consumer B was not provided with an opportunity to do woodwork. However, I consider the service was not aware of this particular goal of the consumer and expressed its commitment to work with the consumer on how to facilitate this activity.
* Evidence presented in relation to Consumer A in relation to wandering intrusive behaviour and lack of coordinated plan to manage Consumer A’s behavioural and phycological symptoms of dementia was considered in Standard 2 Requirement (2)(3)(a) and Standard 3 Requirement (3)(b) which I found to be Non-compliant.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirement (3)(c) in Standard 4 Services and supports for daily living.

### 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 NON-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 Non-compliant as one of the three specific requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(b) in this Standard as not met. The Assessment Team found the service was unable to demonstrate the service environment was safe and clean, and that it enabled consumers to move freely, both indoors and outdoors.

Based on the Assessment Team’s report and the Approved Provider’s response I find Requirement (3)(b) in this Standard Non-compliant. I have provided reasons for my findings in the respective Requirement below.

In relation to Requirement (3)(a) and (3)(c) in this Standard, the Assessment Team found the service was able to demonstrate the service environment was welcoming, easy to understand and optimised each consumer’s sense of belonging, independence, interaction and function. Overall, sampled consumers considered that they feel safe and comfortable in the organisation’s service environment. Specific examples provided by consumers included:

* Consumers reported satisfaction with the furniture and fittings at the service and said, their rooms are spacious which allows space for family and visitors to visits.
* Two consumers who utilise mobility aids said they enjoy the space of their rooms as it allows for them to move around.
* Consumers and representatives said consumers’ rooms are cleaned daily, and shared equipment is cleaned after use.
* Consumers interviewed said they can bring their own portable electrical and the service’s maintenance officer will test to ensure the item is safe to use.
* The Assessment Team observed the service environment to be welcoming and home-like. There was adequate lighting, sufficient space to mobilise and pictures, signs and posters were at a comfortable eye level.

Staff said consumers rooms are cleaned daily and the service environment inside was observed by the Assessment Team mostly clean and well-maintained. The Assessment Team observed furniture, fittings, and equipment to be safe, clean, and maintained. Cleaning schedules were in place to ensure furniture and equipment used by consumers is clean and in good condition.

Fire and emergency management procedures and provisions were in place, and staff demonstrated their awareness of the procedures and reported they complete yearly fire and emergency mandatory training.

Based on the Assessment Team’s report and the Approved Provider’s response I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, Compliant with Requirements (3)(a) and (3)(c) 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) Non-compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The Assessment Team found the service was unable to demonstrate the service environment is safe, clean and well maintained and that it enables consumers did to move freely, both indoors and outdoors. The Assessment Team provided the following information and evidence relevant to my finding:

* Not all consumers were able to move freely inside and outside due to the environment being secured by keypad access.
* Carpeted areas in the dining and lounge areas in one of the wings were stained with marks in most areas, including in the corridor.
* All sliding doors’ tracks were observed to be dirty on the inside and outside.
* Chemicals were not stored in a locked cupboard on the cleaner’s trolleys used throughout the service and accessible to consumers.

The Approved Provider submitted a response the Assessment Team’s report and accepts the findings in the Assessment Team’s report. The Approved Provider has commenced an action plan to address the deficiencies identified in the Assessment Team’s report, actions include but are not limited to:

* All consumers have been provided with security codes to enable them to enter and exit the service as they desire.
* Staff have been instructed to keep all doors that are not required to be secured to be opened and to do the evening safety check of the building, ensuring all consumers are inside and safe.
* Cleaning of the window tracks has been added to the maintenance schedules.
* New lockable boxes have been purchased for the cleaning trolleys to secure chemicals.
* Stained carpet is scheduled to be replaced by vinyl boards and the service is awaiting the installation.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate the service environment was safe, clean and consumers were able to move freely outdoors and indoors.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

### 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 recommended Requirement (3)(c) in this Standard as not met. The Assessment Team found the service was unable to demonstrate appropriate action is taken in response to all complaints and an open disclosure process is used when things go wrong.

Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view from the Assessment Team and have found Requirement (3)(c) in this Standard to be Compliant. I have provided reasons for my findings in the specific Requirement below.

In relation to Requirements (3)(a), (3)(b) and (3)(d) in this Standard, the Assessment Team found overall, sampled consumers consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Specific comments and feedback from consumers include:

* Consumers stated they feel comfortable talking to management or staff about any issues they may have.
* One consumer said they are happy to talk to staff if they have any issues and it always gets rectified.
* One consumer said they attend resident meetings and found it beneficial.
* One consumer was not satisfied their issues or concerns were appropriately addressed.

The service has a complaints management policy available to all staff detailing the complaints handling process and provides information regarding the steps involved for staff when dealing with complaints.

Information about providing feedback, both internally and externally, is provided to consumers in the resident handbook, as well as posters and pamphlets located throughout the facility. The organisation has written materials about how to make complaints, including details for advocates and language services, and these are made available throughout the facility, including in languages other than English.

Management provided examples of how feedback and complaints are reviewed and used to improve the quality of care and services. Management described the main areas where complaints had been made and how continuous improvement processes were used to rectify the issues.

The Assessment Team identified the complaints register was not up-to-date at the time of the site audit which have been rectified by the end of the visit.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with 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.*

The Assessment Team found the service was not able to demonstrate appropriate action is taken in response to all complaints and an open disclosure process is used when things go wrong.

The Assessment Team provided the following information and evidence relevant to their recommendation of not met:

* One consumer said they were not satisfied with the resolution of their complaint in relation to a consumer with wandering behaviours who was entering theirs and other consumers’ rooms uninvited. The service offered a retractable screen over the complainant’s doors which was accepted by the consumer.
* The service’s feedback log showed out of 14 feedback/complaints, 10 were noted to be ‘in progress’ with no actions or outcome recorded. All ten items were lodged on the same day, 7 March 2022. Management was able to provide follow up forms for 8 complaints/feedback with actions documented. Management said the person responsible for updating the feedback log was new to the role and they were in the process of updating the log.
* None of the complaints follow up forms document an apology was provided to consumers and/or representatives.
* The service was unable to demonstrate they have an effective open disclosure process because one member of management team was unable to provide an example and/or evidence of when open disclosure was utilised.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* A new register was implemented in July 2022 to accurately capture all feedback and complaints received from various sources including through electronic care management system feedback form, the Consumer Experience Survey and Resident meetings.
* A new process is planned to be implemented where relevant information from Resident meeting minutes is transferred to the register on a monthly basis.
* Feedback and complaints training for all staff is set for September 2022.
* Management met with the complainant mentioned in the Assessment Team’s report to obtain further feedback in relation to their level of satisfaction with new strategies put in place to better manage wandering behaviours of the consumer mentioned in the complaint. The service confirmed the complainant chose to keep the screen over their doors.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

* I acknowledge one consumer expressed they were dissatisfied with a solution offered by the service to stop a consumer with advanced dementia from entering the complainant room uninvited. However, I consider the service followed the complaint management process. The service met with the consumer, listened to their concerns, and offered a solution the consumer consented to. The solution was a retractable screen over doors which the provider offered as they considered it was the most effective way to deter a wandering consumer from entering the complainant’s room.
* I accept, the complaints register was not up to date at the time of the site audit. However, I consider management was able to find and presented to the Assessment Team information regarding follow up actions in relation to dissatisfactory comments raised by some consumers answering survey questions during the site audit.
* Information and evidence presented in front of me shows 8 consumers’ feedback lodged in the register was feedback from consumers in response to a survey the service routinely conducts with each consumer to gauge their satisfaction with various aspects of care and services. It appears consumers’ feedback was acknowledged, and actions taken. Apart from one feedback from a consumer regarding retractable screen doors, there are no other comments from other consumers in the Assessment Team report indicating dissatisfaction with follow up actions when they provided feedback to the service about dissatisfaction with some aspects of their care or services.
* I acknowledge one member of the management team were not able to provide specific examples of when an open disclosure was used following incidents. However, I consider the service has a policy on open disclosure, and two staff members were able to describe how they practice open disclosure by expressing sorrow, apologising and practice an open and transparent approach following incidents. There is no evidence in front of me that shows consumers reported to the Assessment Team staff do not apologise when something goes wrong. Whilst there was no documented evidence of staff apologising to consumers when incidents happen that harmed or could potentially harm a consumer, it does not mean open disclosure did not occur.
* I acknowledge, the choice of words used in the complaints register in response to some consumers’ feedback does not show genuine interest was shown by a person dealing with a negative piece of feedback, and I encourage the provider to ensure staff consistently choose words indicating they care. An example of this would be a staff member statement in the register “Consumer stated that she is fine and that she does the things that she wants” in response to the consumer’s feedback that they do not always feel they have a say in their daily activities.
* In coming to my finding, I have also considered information presented in this Standard in other Requirements where consumers reported they are comfortable talking to staff and management about any issues and feel like they are listened to. All but one consumer interviewed by the Assessment Team were satisfied their issues or concerns were appropriately addressed.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

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

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

# STANDARD 7 NON-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 Non-compliant as one of the five specific requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) and (3)(c) in this Standard as not met. The Assessment Team found the service was unable to demonstrate 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 and that the workforce is competent and has the knowledge and skills to effectively perform their roles.

Based on the Assessment Team’s report and the Approved Provider’s response I find Requirement (3)(a) in this Standard Non-compliant. However, I have come to a different view from the Assessment Team and have found Requirement (3)(c) in this Standard to be Compliant. I have provided reasons for my findings in the respective Requirements below.

In relation to all other Requirements in this Standard, most sampled consumers consider they get quality care and services when they need them and from staff who are kind, caring, competent and skilled. Specific feedback from consumers/representatives sampled include:

* Most consumers and representatives confirmed staff are kind, caring and respectful of consumers. One consumer provided feedback regarding not being satisfied all on one occasion workforce interactions was kind towards her.
* Consumers and representatives felt staff are skilled and competent to meet consumers’ care and service needs, including knowing what they are doing.

Staff interviewed indicated they are provided with education, training and support on commencement of employment and on an ongoing basis. Management described the processes they use to monitor staff competency and capability, including monitoring professional registrations, providing orientation and training, and using observations, feedback, audits and incidents. Management indicated the training program is informed by staff performance issues and appraisals, incidents, legislative updates and feedback. Staff confirmed management monitor their performance and management described how staff performance is reviewed during probation and two-yearly thereafter.

Mandatory training records for 2022 demonstrate staff have completed training and competencies in relation to infection control, elder abuse and reporting requirements. The probation review and staff appraisals folder contained information to demonstrate new staff performance is monitored and reviewed regularly and that yearly appraisals are conducted.

Based on the Assessment Team’s report, Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-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.*

The Assessment Team found the service was unable to demonstrate 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. The Assessment Team provided the following information and evidence relevant to my finding:

* Five consumers interviewed said there are not always enough staff to provide adequate care and services. They said wandering consumers are not provided adequate supervision to prevent them from entering other consumers rooms. Two consumers reported their mental health is impacted by ongoing intrusive behaviours of the wandering consumers.
* Three staff interviewed confirmed they do not have sufficient time to provide care in line with one consumer’s assessed needs who requires constant supervision and physical assistance with mobility.
* One staff interviewed said they do not always have enough time to monitor consumers with challenging behaviours.
* The Assessment Team observed one consumer on all four days of the Site Audit wandering throughout the service without any staff supervision and/or hands on physical assistance as per the consumer’s assessed needs.
* The service has not been conducting call bell audits in accordance with the organisation’s process. Call bell data from 13 to 25 June 2022 showed significantly increased frequency of above 15 minutes call durations which is one of the service’s key performance indicators.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* Review of staff rostering has been completed and staff were reallocated to the area of higher acuity of care.
* Rostered hours have been reviewed and extended by altering shift hours in afternoon.
* Call bell trends will be disseminated to staff monthly via electronic care management system.
* The service has been working with several external providers to attract trainees and support the local workforce to source both work experience and permanent employment.

### Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

### I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate 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.

### I consider the service has not demonstrated there are sufficient numbers of staff to ensure the delivery and management of safe and quality care and services. I have considered feedback from five consumers which indicates they are not satisfied with staffing levels and how, due to insufficient staffing numbers, consumers with wandering behaviours lack adequate supervision and engagement in meaningful activities. Two consumers reported their mental health is impacted by ongoing intrusive behaviours of the wandering consumers.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

### 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.*

The Assessment Team found the organisation did not adequately demonstrate the workforce is competent and has the knowledge and skills to effectively perform their roles.

The Assessment Team provided the following information and evidence relevant to their recommendation:

* Management did not identify consumers who were subject to environmental restraint and seclusion.
* Consumers who were subject to chemical restraint did not have behaviour support plans and informed consent in their care planning documentation.
* One member of management team was not aware consumers who are subject to chemical restraint required specific behaviour support plan.
* Six consumers prescribed antipsychotic medications do not consistently have care plans, assessments and/or behaviour support plans in line with legislated requirements.
* Care plans did not include sufficient information within care documentation to guide staff in management of challenging behaviours.
* A progress note did not demonstrate chemical restraint was used as a last resort after exhausting all other options.
* Documentation shows staff do not ensure behavioural management strategies were trialled prior to administering as required antipsychotic medications.
* Management was unable to demonstrate training and education has been provided in relation to restrictive practices, falls, behaviours management, open disclosure and dignity of risks.
* Management was unable to provide any examples and/or evidence of when open disclosure was utilised.
* Staff said they don’t always have time to complete the online training in their own time at home.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* Additional education is planned to be delivered to key clinical personnel relating to restrictive practices, behaviour support plans and Serious Incident Response Scheme (SIRS) reporting.
* A new training framework has been introduced which provides for additional training and support for staff while onsite. A new training plan for the remainder of 2022 has been created and distributed to staff.
* Review of position descriptions is planned to ensure clear documentation of the individual role and responsibilities.
* A review of policies, procedures and local work instructions was undertaken to ensure staff are provided with clear guidance and direction in relation to compliance.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

In coming to my finding, I have considered evidence presented in this Requirement and in other Requirements in Standard 7 that shows the following:

* All sampled consumers and consumers’ representatives felt staff were well trained and competent at meeting their needs.
* Staff credentialing is completed during the recruitment stage and monitored.
* The service has an onboarding process in place which includes a site orientation, mandatory training based on job roles and buddy shifts.
* There is a process in place to identify and address staff skill gaps and training needs through a range of mechanisms including staff performance appraisals, incident data, consumer feedback, staff feedback and audits.
* Staff in a variety of roles said they are required to complete mandatory training specific to their role annually, and documentation reviewed confirmed this occur.
* Annual clinical staff competencies are completed and maintained in staff personnel files. Onboarding processes for staff and contractors supporting that the service ensures staff are trained, equipped, and supported to undertake their roles.

I consider the Assessment Team’s finding in relation to the service not being able to recognise there were consumers who were subject to environmental restraint reflects core deficiency in Standard 8 Requirement (3)( e) specifically in relation to implementation of a clinical governance framework. There was no evidence in the Assessment Team’s report that demonstrates consumers were subject to seclusion.

I have considered information in relation to six consumers who the Assessment Team identified were subject to chemical restraint and who did not have behaviour support plans and informed consent in their care planning documentation. I was not able to use this information in coming to my finding in this Requirement due to the absence of information regarding the consumers’ diagnoses and the intent of its use and that the medication was used by staff for purposes of influencing the consumers’ behaviours. For the same reason, I could not consider the Assessment Team’s statement that a progress note did not demonstrate chemical restraint was used as a last resort after exhausting all other options as this was not supported by evidence.

Whilst the Assessment Team found management was unable to demonstrate training and education has been provided to staff in relation to restrictive practices, falls, behaviours management, open disclosure and dignity of risks, I find this is more relevant to Requirement 7(3)(d) where this information was considered.

I accept, one member of management team was not able to provide an example of when open disclosure was utilised. However, I considered management acknowledged during the site audit there were some deficits in this staff member knowledge who are very new to the role and would be provided with additional training and support to continue in the role.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirement (3)(c) in Standard 7 Human resources.

### 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 one of the five specific Requirements has been assessed as Non-compliant.

## The Assessment Team have recommended Requirement (3)(e) in this Standard as not met. The Assessment Team found the service was unable to demonstrate an effective clinical governance framework is in place in relation to minimising the use of restraint.

## Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with Requirement (3)(e) in this Standard. I have provided reasons for my decision in the specific Requirement below.

## In relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in this Standard, the Assessment Team found the organisation demonstrated that they involve consumers in the design, delivery and evaluation of care and services, providing examples of how consumers are involved in the co-design of services and engaged on a day-to-day basis.

## Consumers said the service is well run and they are involved in the evaluation and development of care and services delivered at the service through meetings and case conferences. Consumers provided examples of consultation about meals, lifestyle activities and events held at the service.

The clinical governance framework, communication with consumers flowchart and a customer feedback documentation highlighted the service’s commitment to encouraging consumers and representatives to provide feedback and that staff are to treat any feedback with respect and fairness.

The organisation has a range of reporting mechanisms to ensure the Board is aware of undertakings within the service and is accountable for the delivery of services.

The organisation has a range of policies and procedures to ensure effective governance systems guide staff when providing care and identifying and managing risks. Management described how they manage high impact or high prevalence risks associated with the care of consumers through leadership, governance meetings and a range of staff meetings to ensure effective communication across all levels of the organisation.

The service has incident reporting systems to identify and respond appropriately to risks associated with consumer care and risks associated with elder abuse.

The service has an established and documented clinical governance framework, including policies and other guidance material relating to antimicrobial stewardship, minimising the use of restrictive practices, and use of an open disclosure approach. However, the implementation of new restrictive practice legislation was not effective.

Based on the Assessment Team’s report, Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(d) 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) 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.*

### Requirement 8(3)(d) 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.*

### Requirement 8(3)(e) Non-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.*

Whilst the Assessment Team found the service had an effective clinical governance framework around antimicrobial stewardship, the service could not demonstrate an effective framework is in place in relation to open disclosure and minimising the use of restraint. The service has policies and procedures in place in relation to restrictive practices, however these have not been effectively implemented to ensure the service is complying with legislative requirements and minimising the use of restraints. The Assessment Team provided the following information and evidence relevant to my finding:

* The service did not recognise they used restraints within the service including chemical, environmental and seclusion and did not have documented evidence to demonstrate that relevant assessments were completed, informed consent was taken, and best practice strategies are incorporated into consumer behaviour support plans in line with legislative requirements. The Assessment Team provided the following evidence to support their finding:
  + During the entry meeting management said they do not have any environmental restraints or seclusion.
  + However, two consumers had retractable screens over their doors and required staff assistance with using the screen which compromised their free movement in and out of their room. The Assessment Team found this form of restrictive practices was seclusion.
  + Multiple consumers did not have keypad access to allow free movement inside between the service’s wings and could not leave the service. However, the service did not recognise this as environmental restraint and did not ensure all relevant steps are taken in line with legislative requirements including assessments, informed consent and evidence that this form of restrictive practice was used as a last resort.
  + The service sent a letter to representatives of all consumers who are prescribed psychotropic medications advising them of changes to legislation and the requirement for all consumers subjected to restrictive practices including chemical restraint to have a behaviour support plan and consent from the representative to administer the medication when needed. The letter requested the representative to sign the document and return it to the service.
  + One consumer was administered medications prescribed with the purpose of influencing their behaviour and not to treat the diagnosed disorder or enable the treatment of a diagnosed disorder or condition, did not have documented evidence of informed consent.
  + The Assessment Team’s report referred to Standard 3 Requirement (3)(b) for information to support their finding consumers who were subject to chemical restraint did not have behaviour support plans and restrictive practice authorisation.

The Approved Provider submitted a response to the Assessment Team’s report and provided the following information and evidence relevant to my finding:

* The service obtained consent from a consumer’s representative who was chemically restrained to manage behavioural and psychological symptoms of dementia.
* The service is planning to send a letter to the families to gain their consent for psychotropic medication. Clinical staff will be meeting with the families to explain the reason and side effects of each psychotropic medication prescribed.
* All consumers who are prescribed psychotropic medications are planned to be reviewed and effectiveness of strategies to manage displayed behaviours are planned to be discussed at the Clinical Governance Meeting.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with this Requirement.

Whist the service has systems and process around minimising use of restrictive practices, these were not successfully implemented. I acknowledge, in response to the Assessment Team’s report, the service conducted a risk assessment of retractable screen doors for relevant consumers. However, the service still considers the use of the screen was not an environmental restraint but a risky activity a consumer was choosing to take to have a better quality of life. I consider the service did not use the correct assessment tool to accurately assess the restrictive practice, did not recognise this as a restrictive practice and did not capture this information accurately in line with its clinical governance framework underpinned by policies and procedures around restrictive practices.

In coming to my finding, I have considered there is insufficient evidence in front of me that supports the Assessment Team’s finding that the service does not minimise use of chemical restraint or that there are deficiencies in the framework to enable the service to do so. I considered lack of detail in consumers’ care plans regarding non-pharmacological strategies to manage a behaviour of concern under Standard 2 Requirement (3)(a) which I found Non-compliant.

In coming to my finding, I have also considered information presented in the Assessment Team report in Standard 3 Requirement (3)(b) where the Team found 4 of the 5 sampled consumers were prescribed either antidepressant or hypnotic medications which are classified as psychotropic medications and were not identified as a form of chemical restraint by the service. I was not able to use this information due to the absence of supporting evidence regarding the consumers’ diagnoses and the intent of its use and that medication was used by staff for purposes of influencing the consumers’ behaviours.

For the reasons detailed above, I find Star of the Sea Home for the Aged, in relation to The Catholic Diocese of Port Pirie Inc, to be Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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. The service should seek to ensure:

* In relation to Standard 2 Requirement (3)(a):
  + Assessment and planning process is comprehensive and includes consideration of risks to the consumer’s health and well-being to inform the delivery of safe and effective care.
* In relation to Standard 3 Requirement (3)(b):
  + Consumers’ high impact or high prevalence risks are effectively managed, including risks associated with choking/aspiration, responsive behaviours and unwitnessed falls.
* In relation to Standard 5 Requirements (3)(b):
  + The service environment is safe and enables consumers to move freely, both indoors and outdoors.
* In relation to Standard 7 Requirements (3)(a):
  + Staffing levels are sufficient to ensure consumers’ needs and preferences are met.
* In relation to Standard 8 Requirements (3)(e):
  + Ensure the service implements restrictive practice frameworks and policies and procedures effectively, including monitoring of staff practice and knowledge in relation to restrictive practice.