Performance

Report

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| Name of service: | Star of the Sea Home for the Aged |
| Service address: | 15 Elizabeth Street WALLAROO SA 5556 |
| Commission ID: | 6028 |
| Approved provider: | The Catholic Diocese of Port Pirie Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 25 July 2023 to 26 July 2023 |
| Performance report date: | 29 August 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 Star of the Sea Home for the Aged (**the service**) has been prepared by M Glenn, 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.

# 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 consumer and staff;
* an email from the provider received 18 August 2023 indicating a response to the assessment team’s report would not be provided; and
* a Performance Report dated 31 August 2022 for a Site Audit undertaken from 28 June 2022 to 1 July 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 28 June 2022 to 1 July 2022 as effective processes to ensure each consumer had appropriate assessments completed to inform and develop strategies were not demonstrated. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed assessments to ensure appropriate assessments were completed to inform and develop strategies in each consumer’s care plan.
* Implemented clinical staff huddles and toolbox sessions to provide staff with ongoing education regarding assessment, planning and identification of risk, including wound and pain management.

At the Assessment Contact undertaken in July 2023, care files demonstrated a range of assessments are completed on entry and on an ongoing basis. A range of validated risk assessment tools are also used to inform care planning. Information gathered from assessment processes is used to develop a care plan which incorporates each consumer’s needs, preferences, goals and strategies to minimise identified risks. Staff described assessment process and said care plans include sufficient information to enable them to deliver effective and safe care to consumers. Consumers interviewed were happy with the care they receive and with the information provided about their care.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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)(g) | 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. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 28 June 2022 to 1 July 2022 as high impact or high prevalence risk associated with consumers’ care were not effectively managed. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Oversight of review of care plans by the residential service manager to ensure all high impact or high prevalence risks associated with consumers’ care are reflected.
* Implemented a more comprehensive falls prevention and management local work instruction.
* Provided education sessions to staff on falls management, restrictive practices, managing challenging behaviours, chemical restraint and open disclosure.
* Created a local work instruction on behaviour management, clinical incidents, risk management and clinical documentation.
* Implemented an alert system for easy identification of consumers who have a history of displaying aggression.

At the Assessment Contact undertaken in July 2023, high impact or high prevalence risks associated with the care of consumers were found to be identified through assessment processes with management strategies developed and documented in care plans to ensure care and services are delivered in line with consumers’ assessed needs and preferences. Care files demonstrated appropriate assessment and strategies to mitigate risks relating to weight loss, choking, falls, restrictive practices and behaviour. Medical officers and allied health specialists were also noted to be involved in assessment of high impact or high prevalence risks, with recommendations actioned. Staff described strategies and interventions for risk prevention to ensure consumers remain safe, in line with sampled consumers’ care plans, and consumers interviewed confirmed they get the care they need and feel safe.

In relation to requirement (3)(g), appropriate infection control practices were demonstrated through the effective management of a COVID-19 outbreak which was contained to one area. Staff described actions taken to prevent the spread of COVID-19 and consumers expressed satisfaction with the management of outbreaks. Staff were familiar with actions to prevent infection and the requirement for a positive COVID-19 test before commencing antiviral therapy. Staff described general actions to prevent the spread of infection, including hand hygiene and use of personal protective equipment and ensuring personalised care for consumers, such hydration and hygiene needs are met to prevent urinary tract infections. Where an infection is suspected, staff confirmed they monitor for symptoms and arrange pathology prior to commencement of antibiotics.

For the reasons detailed above, I find requirements (3)(b) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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. | Compliant |

Findings

Requirement (3)(b) was found non-compliant following a Site Audit undertaken from 28 June 2022 to 1 July 2022 as the service environment was not safe and clean and consumers were not able to move freely outdoors and indoors. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, removal of retractable screens across consumers’ bedroom doors.

At the Assessment Contact undertaken in July 2023, the environment was found to be safe, well maintained and allowed consumers to move freely indoors and outdoors. Communal areas and courtyards were observed to be clean, safe and accessible to consumers, and documentation sampled showed door codes had been provided to consumers and were referenced in consumer handbooks. There are preventative and reactive maintenance processes in place which are supported by contracted services, and staff described reporting processes for maintenance requests and hazards, in line with the service’s processes. Staff also said they had received training in relation to restrictive practices and described aspects of environmental restraint that falls within the scope of restrictive practice. Consumers interviewed expressed no concerns for safety, cleanliness and accessibility within the environment.

For the reasons detailed above, I find requirement (3)(b) in Standard 5 Organisation’s service environment compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 28 June 2022 to 1 July 2022 as the service did not demonstrate the workforce was planned to enable, or the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Conducted a roster review resulting in the reallocation of staff to areas of higher care needs.
* Implemented a system for reporting human resource trends as part of monthly care and service trending, and conducting human resources audits every six months.
* Implemented an unplanned leave shift replacement form to assist in tracking and trending of short notice personal leave to ascertain impacts to care and service delivery.
* Recruited a registered nurse, four hospitality and six care staff.
* Developed a staff training plan to ensure staff knowledge of best practice, safe and effective clinical care and consumer service delivery.

At the Assessment Contact undertaken in July 2023, staff roster allocation sheets for the two weeks preceding the Assessment Contact confirmed sufficient number and skill mix across different working designations and level of expertise. There are processes for planned and unplanned leave. The service does not currently have a registered nurse onsite 24 hours a day, with a registered nurse working morning and afternoon shifts. A registered nurse on call system is utilised for night shifts to support a supervising enrolled nurse. However, a registered nurse has been employed for night duty and will commence in August 2023. Staff said they generally have sufficient workforce to provide care and services. Consumers confirmed while staff are often busy, there are adequate numbers of staff with appropriate skills to provide safe and quality care and services. Consumers said they have confidence in the abilities of staff across all designations and do not usually experience delays in care and service provision.

For the reasons detailed above, I find requirement (3)(a) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| 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

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 28 June 2022 to 1 July 2022 as the service did not demonstrate effective systems to minimise use of restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Removed all forms of environmental restraint and seclusion and reassessed consumers who require restraint to ensure correct practices are followed.
* Updated and/or created behaviour support plans for all consumers on chemical restraint.
* Created frameworks for open disclosure and minimising use of restraint and developed local work instructions relating to behaviour support plans and restrictive practices.
* Developed a staff training plan to improve staff knowledge of behavioural management, restrictive practice and behaviour support plans.
* Sent letters to consumers and representatives relating to use of chemical restraint, with additional information regarding individual risks to consumers.

At the Assessment Contact undertaken in July 2023, an effective clinical governance framework, inclusive of antimicrobial stewardship, minimising use of restraint and open disclosure was demonstrated. The framework is supported by policy and procedure documents to guide staff practice and systems to identify areas of continuous improvement. The use of restrictive practices is monitored and discussed at monthly clinical meetings. An infection prevention control lead is in place and ensures oversight and management of infections, including COVID-19 outbreaks and monitoring of antimicrobial usage across the organisation to ensure best practice guidelines are met. Behavioural and fall incidents, infections, unexplained weight loss, wounds and complaints data is collected and analysed for trends on a monthly basis and reported to various committees locally and organisationally, as well as to the Board. Areas for improvement are identified and documented in the plan for continuous improvement for action.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance compliant.

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