Dunbar Homes Salisbury

Performance Report

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**Commission ID:** 6139

**Provider name:** Dunbar Homes Incorporated

**Assessment Contact - Site date:** 31 August 2020

**Date of Performance Report:** 1 October 2020

# Publication of report

This Performance Report **may 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 3 Personal care and clinical care** |  |
| Requirement 3(3)(b) | Non-compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commission’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 Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, staff and others
* the provider’s response to the Assessment Contact - Site report received 24 September 2020.

# STANDARD 3 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 Assessment Team assessed Requirement (3)(b) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The Assessment Team recommended Requirement (3)(b) in Standard 3 as not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 and find the service Non-compliant with Requirement (3)(b). I have provided reasons for my decision in the specific Requirement.

### Assessment of Standard 3 Requirements

### 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 each consumer, specifically in relation to an Insulin dependent diabetic consumer. The Assessment Team provided the following evidence relevant to my decision:

In relation to a consumer, who is an Insulin dependent diabetic:

* A medication chart included Insulin orders and instructions for administration and frequency of blood glucose level (BGL) readings. However, therapeutic ranges were not documented and further information to direct staff in relation to diabetes management was not included.
* Documentation viewed included inconsistent information relating to frequency of BGLs and therapeutic ranges, for example:
* An Insulin and BGL reporting chart indicated BGLs are to be taken once a day with the therapeutic range recorded between 3 and 22mmol/L.
* The Diabetes management plan indicated BGLs are to be taken three times a day with the therapeutic range recorded between 5 and 18mmol/L.
* The Medication chart indicated frequency of BGLs as three times a day, and directed staff to administer Insulin if BGLs are above 22mmol/L.

Clinical staff acknowledged the inconsistencies in relation to therapeutic ranges and stated this had been discussed with the Medical officer. Clinical staff stated the Medical officer verbally advised the therapeutic range was between 5 and 18mmolL.

* On three occasions in August 2020, the consumer’s BGL readings were lower than the therapeutic range of 5mmol/L. There was no evidence recorded as to how the low readings were managed or that the low readings were reported to the consumer’s Medical officer.
* The consumer was seen by a Dietitian in July 2020 in response to non-compliance with their diet. The Dietitian’s recommendations had not been recorded on the consumer’s Diabetes management plan or Nutrition and hydration plan. Recommendations included maintaining a record of food intake for three to five days; this had not been actioned. Additionally, three staff interviewed were unaware of the Dietitian’s recommendations.
* Risks associated with non-compliance to the recommended diet had not been discussed with the consumer.

The approved provider’s response indicated they agreed with the Assessment Team’s findings. The response demonstrates the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and have implemented or are implementing the following actions:

* Engaged external Aged care specialists to provide independent guidance to meet required improvements.
* Addressing gaps in diabetes management protocols and practices.
* Developing an integrated risk management framework addressing high impact or high prevalent risks.

The approved provider’s response indicates all improvements will be evaluated for effectiveness and consumer outcomes and monitored on an ongoing basis to prevent reoccurrence.

I acknowledge the approved provider’s proactive response to the Assessment Team’s findings. However, I find that at the time of the Assessment Contact, the service did not effectively manage high-impact or high-prevalence risks associated with the care of each consumer. Documentation relating to diabetes management for one consumer included inconsistent information relating to frequency of BGLs and therapeutic ranges. Where the consumer’s BGL had been recorded below the therapeutic range, actions to address the low BGLs had not been taken and/or recorded.

I also find, in relation to one consumer, Dietitian recommendations had not been incorporated into the consumer’s Diabetes management plan or Nutrition and hydration plan and a food intake chart had not been initiated. Additionally, three staff interviewed by the Assessment Team were not aware of the Dietitian’s recommendations.

For the reasons detailed above, I find Dunbar Homes Incorporated, in relation to Dunbar Homes Salisbury, Non-compliant in relation to Standard 3 Requirement (3)(b).

# STANDARD 8 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 Assessment Team assessed Requirement (3)(e) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The Assessment Team recommended Requirement (3)(e) in Standard 8 as not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service Non-compliant with Requirement (3)(e). I have provided reasons for my decision in the specific Requirement.

## Assessment of Standard 8 Requirements

### 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.*

The service has effective clinical governance systems in relation to the provision of clinical care and minimising the use of restraint. However, the Assessment Team found the organisation did not demonstrate a clinical governance framework to enable the effective management of infection control. The Assessment Team provided the following evidence relevant to my decision:

* The Business and operations manager said the service’s outbreak management plan is a work in progress. A copy of the Department of Health ‘First 24 Hours – Managing COVID-19 in a Residential Aged Care Facility’ document viewed by the Assessment Team included hand written notes reflecting information to be included in a COVID-19 outbreak management plan.
* The Assessment Team viewed a folder containing printed copies of information, such as the Communicable Diseases Network Australia (CDNA) guidelines, handwashing procedures and other information from various sources. Management said they believed the resource folder provided sufficient information in lieu of a formal COVID-19 outbreak management plan.
* The Infection control – Outbreak management plan issued May 2020 reflects general information relating to management of infections. The plan does not include information required by the CDNA guidelines, including identification or contact details of the outbreak management committee or outbreak coordinator and allocated roles are not identified. Contact details for external organisations, including the Public Health Unit, Department of Health, Medical officers and surge workforce organisations are not recorded.
* Management said the service has discussed but not recorded how the service would address the segregation of areas of the home if this was necessary.
* Management said the service has discussed but not recorded information relating to surge contingency workforce management.
* Clinical and care staff were unsure if a specific plan was in place for the management of a COVID-19 outbreak and said they would be guided by management at the time.

The approved provider’s response indicated they agreed with the Assessment Team’s findings. The response demonstrates the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and have implemented or are implementing the following actions:

* Engaged external Aged care specialists to provide independent guidance to meet required improvements.
* Developing an effective clinical governance framework.
* Undertaking a comprehensive gap analysis of COVID-19 risk management systems against best practice.

The approved provider’s response indicates all improvements will be evaluated for effectiveness and consumer outcomes and monitored on an ongoing basis to prevent reoccurrence.

I note and acknowledge the approved provider’s response includes clarification relating to the Assessment Team’s responses on the Infection Control Monitoring Checklist.

I acknowledge the approved provider’s proactive response to the Assessment Team’s findings. However, I find that at the time of the Assessment Contact, the service did have an appropriate outbreak management plan in place to enable effective management of a COVID-19 outbreak in accordance with the CDNA guidelines. The service’s outbreak management plan was noted to be a work in progress. Additionally, staff did not have access to clear directives to assist them to manage an outbreak of COVID-19 should one occur.

For the reasons detailed above, I find Dunbar Homes Incorporated, in relation to Dunbar Homes Salisbury, Non-compliant in relation to Standard 8 Requirement (3)(e).

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 3 Requirement (3)(b)**

* Ensure staff have the skills and knowledge to:
	+ Undertake blood glucose monitoring in line with each consumer’s Medical officer’s directives, ensuring blood glucose levels outside of desired range and monitored and communicated.
	+ Implement recommendations and review consumer care and services following allied health reviews.
* Review processes and practices relating to diabetes management and implementation of allied health recommendations.
* Review consumer documentation in relation to diabetes management, ensuring consistency of information to enable staff to provide effective care.
* Ensure policies and procedures in relation to diabetic management and allied health referrals are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies and procedures in relation to diabetes management, including reporting, review and monitoring.

**Standard 8 Requirement (3)(e)**

* Develop an Outbreak management plan inclusive of COVID-19 and reflective of CDNA guidelines for Residential Care Facilities.
* Ensure plans and procedures in relation to management of COVID-19 outbreaks are effectively communicated and understood by staff.