Murray Mudge

Performance Report

7 Raymond Grove
GLENELG SA 5045
Phone number: 08 8375 1111

**Commission ID:** 6017

**Provider name:** Uniting Communities Incorporated

**Assessment Contact - Site date:** 17 September 2020

**Date of Performance Report:** 4 January 2021

# 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** | **Non-compliant** |
| Requirement 3(3)(b) | 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 staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received 7 October 2020.

# STANDARD 3 NON-COMPLIANTPersonal 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 Non-Compliant as one of the seven specific Requirements in this Standard has been assessed as Non-Compliant.

The Assessment Team assessed Requirement (3)(b) in this Standard, all other Requirements in this Standard were not assessed. An overall assessment of this Standard was not completed at this Assessment Contact.

The Assessment Team have recommended Requirement (3)(b) in this Standard as not met. The Assessment Team found the service did not adequately demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer 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 Uniting Communities Incorporated, in relation to Murray Mudge, to be Non-compliant with Requirement (3)(b) in this Standard. I have provided reasons for my findings in the respective Requirement below.

### 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 did not adequately demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to skin and wound management care. The Assessment Team provided the following information and evidence relevant to my finding:

* Three consumer files reviewed demonstrated staff are not consistently monitoring and recording the size of consumers’ wounds to assist in the determination of wound healing or deterioration.
	+ Several wound photographs for all three consumers were taken from varying angles, proximity and sharpness with no ruler or object to assist in determination of the size of wounds.
* In relation to one consumer’s (consumer A) two pressure injury wounds:
	+ The service did not refer the consumer to a wound specialist or other related health specialists even though pressure injury wounds were deteriorating, with one wound showing signs of necrosis.
		- Directives from other health related specialists in relation to referral and review were not followed by the service.
	+ No new pressure area prevention strategies were implemented following the development and deterioration of two pressure injury wounds.
	+ Wound care for the pressure injuries were not always provided in accordance with the wound treatment plan.
	+ Management stated the pressure injuries were significant wounds and the stage of the wounds had been incorrectly documented by clinical staff as both pressure injuries were stage 3 and stage 4 but had been respectively documented as stage 1 and stage 2 pressure injury wounds.
	+ Repositioning check charts do not support that the consumer was provided with pressure area care in accordance with their care plan. Additionally, staff ceased repositioning check charts even though the consumer continued to have pressure injury wounds which were deteriorating.

The Approved Provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. While the Approved Provider agrees the Assessment Contact has highlighted an opportunity to improve documentation practices, they assert the service has effectively managed high impact and high prevalent risks associated with the care of each consumer. The Approved Provider provided the following information and evidence relevant to my finding:

* In relation to consumer A:
	+ The consumer has been living at the service for several years and the service have provided excellent care in the context of the consumer’s complex physical and mental health history.
	+ The service has worked closely with other health related specialists to support care where required.
	+ The consumer’s pressure injury wounds have been regularly reviewed by registered nurses, and the wound is a longstanding wound which has a history of improving then declining.
	+ In the weeks leading up to the significant deterioration of the pressure injury wounds, the consumer refused care including medication and activities of daily living. The consumer was aware of the risks they were taking in refusing care and the wounds subsequently deteriorated.
	+ Since the Assessment Contact, the service has purchased an alternating and turning mattress to support the consumer’s pressure injury wound healing.
* In relation to monitoring and recording wounds:
	+ The Approved Provider agrees wound photographs and details can be improved.
* Additionally, the service has conducted a holistic review of wound management care and implemented the following actions:
	+ Wound care champions to be appointed within the registered nursing group, including conducting face-to-face wound care training for clinical staff.
	+ Source various wound care specialists to conduct wound reviews if one specialist is unavailable to attend the service.
	+ Implementation of new audit tool for skin and wound care, including clinical management to conduct monthly review of wound photographs
	+ Staff to be reminded that information discussed at handover is to be recorded in progress notes.
	+ Review the service’s wound care procedures to ensure best practice principles are included.
	+ Completed a new pressure injury risk assessment for all consumers and ensure care plans are updated with relevant strategies.
	+ Completing new wounds charts for all consumers to ensure accurate and correct information is captured.

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 service’s improvement actions taken in response to the Assessment Team’s report. However, I find that on the day of the Assessment Contact, the service had not effectively managed the risks associated with the care of consumers who have developed wounds by not monitoring or recording wounds consistently and accurately to support effective wound monitoring, management and healing. The Approved Provider agreed with this finding and immediately implemented several improvement actions to address this issue.

I also find that the service has not effectively managed the risks associated with the care of consumer A who was known to be at high risk of pressure injury development and had known risks associated with the effective management and healing of pressure injury wounds.

* The Approved Provider asserts that the service has worked closely with health specialists to support consumer A’s care, including in relation to the pressure injuries. However, I find that the service did not refer the consumer to a wound specialist or other health specialist to support effective wound healing in a timely manner. Consumer A’s care plan indicates the service were to refer the consumer to a specific health specialist if the consumer was refusing care, however, this did not occur for refusal of care in relation to pressure area care.
* Additionally, the service did not refer consumer A to a wound specialist even though the wound was not healing and/or deteriorating for several weeks. While the Approved Provider asserts registered nursing staff were regularly reviewing the consumer’s wounds, the response demonstrates these reviews were neither consistent nor sufficient to identify if the wound was appropriately healing or deteriorating. In considering the issues identified with wound photographs, I find clinical staff have not effectively reviewed or monitored the consumer’s wound.
* The Approved Provider asserts the consumer refused care, knowing the risks associated with the refusal of this care, which contributed to the wound deterioration. However, evidence was not provided to demonstrate the consumer was refusing pressure area care, rather evidence was in relation to refusal of medications and activities of daily living. Additionally, evidence was not provided that the consumer understands the risks associated with the refusal of pressure area care. The Assessment Team found the service was not utilising pressure area care charts to ensure care had been provided, even though they had previously been used to monitor pressure area care, in the context of the consumer’s refusal of care. I find it reasonable that clinical staff should have increased monitoring of the delivery of pressure area care for Consumer A in the context of their refusal of care and deterioration of pressure injury wounds.
* While the service has purchased a new pressure relieving mattress since the Assessment Contact, the service did not implement new pressure area prevention strategies following the development and deterioration of two pressure injury wounds.

For the reasons detailed above I find Uniting Communities Incorporated, in relation to Murray Mudge, to be Non-Compliant with Standard 3 Requirement (3)(b).

# 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)**
	+ The service has implemented an action plan to address the deficiencies identified by the Assessment Team and have included improvements which directly address the issues identified by the Assessment Team.
	+ The service should seek to ensure:
		- Wound care documentation is consistent with best practice guidelines and is monitored to ensure compliance with these practices.
		- Wound care photographs are taken in a manner to support effective assessment and monitoring of wounds.
		- Pressure area prevention strategies are reviewed and evaluated following changes to skin integrity and relevant interventions implemented.
		- Consultation with wound and other health specialists occurs for wounds which are not healing and/or deteriorating.