Murray Mudge

Performance Report

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**Commission ID:** 6017

**Provider name:** Uniting Communities Incorporated

**Assessment Contact - Site date:** 25 February 2021 to 26 February 2021

**Date of Performance Report:** 16 April 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** |  |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(g) | 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 Approved Provider’s response to the Assessment Contact - Site report received 18 March 2021
* the infection control monitoring checklist completed on 25 February 2021
* the Performance Assessment Report for the Assessment Contact conducted on 17 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 Requirements (3)(b) and (3)(g) in this Standard at this Assessment Contact. All other Requirements in this Standard were not assessed. Therefore, an overall assessment of this Standard has not been provided.

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirement (3)(b) in this Standard. This Requirement was found to be Non-compliant following an Assessment Contact conducted on 17 September 2020 where it was 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 care and wound management.

The Assessment Team have identified effective improvements have been undertaken following the Assessment Contact in September 2020 and have recommended Requirement (3)(b) in this Standard as met. However, the Assessment Team also assessed Requirement (3)(g) in this Standard at this Assessment Contact and have recommended this Requirement as not met. In relation to Requirement (3)(g) in this Standard, the Assessment Team found the service was not able to demonstrate effective standard and transmission-based precautions to prevent and control infection in relation to COVID-19. 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 Compliant with both Requirements (3)(b) and (3)(g) in this Standard. I have provided reasons for my findings in the respective Requirement below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

Following an Assessment Contact on 17 September 2020 this Requirement was found to be Non-compliant because 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 care and wound management. It was found the service had not effectively managed the risks associated with the care of consumers who had developed wounds by not monitoring or recording wounds consistently and accurately to support effective wound monitoring, management and healing. In response to the deficiencies identified, the service implemented improvements, including (but not limited):

* The service appointed and trained two Registered Nurses as wound champions to assist in the review of chronic wounds.
* An external specialist for wound management advice has been utilised for consumers identified at the previous Assessment Contact.
* Wound training was conducted in October 2020 for all clinical staff and training and education resources made available for personal care staff.
* A new wound audit system was implemented to highlight wound care practice and is used as part of monthly clinical governance reporting. Additionally, the Site Manager and Care Manager (CM) produce a wound continuous audit log. The Assessment Team viewed the log which details all the wounds and addresses if the wounds are dressed in the appropriate timeframe.
* Implemented Carer Staff Worksheets which detail which consumers require repositioning, and staff provide verbal reports of pressure area care and changes to skin integrity at the end of every shift to clinical staff.
* Wound management plans have been updated on the electronic care planning system and contain more detailed information.
* Improvements have been made to the process for taking wound photographs, including clinical staff trying to copy the previous photo for reference. A tape measure is now being used in the photographs.
* Several organisational policies and procedures have been reviewed in relation to skin and wound care.

The Assessment Team provided the following findings and evidence in relation to their recommendation of met in this Requirement:

* All consumers and representatives interviewed were satisfied with management of high impact or high prevalence risks, including falls, pain and wound management.
* Three consumers’ files viewed indicated wounds had been reviewed and wound management charts and incidents reports were completed. Wound management charts viewed demonstrated wounds are managed in accordance with documented charts. Wound specialist recommendations have been implemented and a pressure injury for a consumer identified in the previous Assessment Contact is now healing.
* Clinical staff were able to describe improvement to wound management processes and personal care workers were able to describe individual consumer’s repositioning requirements.
* One consumer’s file indicated falls risks have been managed, including the identification of individual strategies to minimise the impact of risk outlined in the care plan. Falls prevention strategies were reviewed following incidents and/or changes to the consumer’s health or well-being and on a regular basis.

For the reasons detailed above I find Uniting Communities Incorporated, in relation to Murray Mudge, to be Compliant with this Requirement.

### 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.*

The Assessment Team found the service did not demonstrate effective standard and transmission-based precautions to prevent and control infection in relation to COVID-

19. The Assessment Team provided the following findings and evidence in relation to their recommendation of not met in this Requirement:

* Six staff interviewed were not able to identify the correct sequence for donning and doffing of personal protective equipment (PPE) in accordance with the service’s processes.
* Management said staff completed an observation of donning and doffing in November 2020 during handover, however, competency training was not completed due to the limited supply of PPE. Training was scheduled for 26 February 2021.
* While the service had an outbreak management plan and guidelines for staff in the event of COVID-19 outbreak, the infection control monitoring checklist identified there was minimal information in this documentation, including:
	+ The plan only listed the contact details of the Executive Manager, the Site Manager and the CM. The plan also contained the Public Health Unit and Department of Health details; however, other details are not contained in the plan, such as Medical Officers and other visiting staff, surge workforce organisations. However, these contact details could be accessed on another list. The clinical waste contractor is not identified in the list of contacts.
	+ The plan did not indicate how to access information in relation to the current staff list with contact details, including detailed rosters, or a record of staff who work across multiple services or multiple sites.
	+ The plan did not indicate how to access the service’s emergency transfer letters, which contains a three-page document for each individual consumer with contact details for representatives, photograph, room number and Medicare number. However, the plan did have instructions in relation to how to access the electronic care system and how to print a list of consumers’ names and representative contact details, but this list does not contain consumer photographs.
	+ The service’s floor plan did not include identified rooms/zones, PPE donning/doffing station locations and apportioning of staff to each area. However, a copy provided later in the Assessment Contact contained this information.
	+ The clinical handover and communication protocol were not available in the plan.
	+ The plan does not include information relating to a surge contingency plan.
* In relation to processes other than COVID-19, the Assessment Team found the service was able to demonstrate minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection. The Assessment Team also found effective practices were used to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. The service monitors infection rates within the service and staff are aware of antimicrobial stewardship practices.

The Approved Provider submitted a response to the Assessment Team’s report and have commissioned the organisation’s Quality Team to address the issues identified by the Assessment Team. However, the Approved Provider asserts that the information identified by the Assessment Team as not being available or noted in the outbreak management plan, was available and accessible on the organisation’s intranet on the day of the Assessment Contact. The Approved Provider submitted the following findings and evidence relevant to my finding:

* Documentation identified by the Assessment Team as not being included in the COVID-19 outbreak management plan was accessible on the day, but this has now been consolidated in a hardcopy format accessible to relevant staff.
	+ Relevant documentation has been updated to include the contact details of Infection Prevention and Control Lead (IPCL). This was listed on the SharePoint outbreak management team site previously.
	+ A list of staff details, staff who work across multiple sites, staff roles and alternative contacts is now available as a hardcopy appendix (communication to relevant staff has occurred) and was always available electronically.
	+ The outbreak management plan now includes information in relation to how to access the emergency transfer letter, clinical handover, and information about the surge workforce and the clinical waste contact details.
	+ The floor plans in all locations have been updated and colour coded to include donning and doffing areas, personal protective supply area and location of resident transfer areas.
	+ Competency testing in relation to donning and doffing of PPE was scheduled for the day of the Assessment Contact and the Assessment Team were shown the training resources and communication relating to the competency testing. All staff (excluding those on extended leave) have now been competency tested. Additionally, staff have participated in personal protective equipment training prior to the Assessment Contact.

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 Assessment Team did find that the service was able to demonstrate minimisation of infection related risks through the implementation of standard and transmission-based precautions to prevent and control infection, and that the service uses practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

In relation to managing a potential COVID-19 outbreak within the service, I find the organisation had developed an outbreak management plan to prevent, detect and control the spread of the COVID-19 infection. While some information was not available or specifically referred to in the COVID-19 outbreak management plan, I find that on the day of the Assessment Contact the outbreak management plan contained sufficient information to guide staff during a potential COVID-19 outbreak.

In coming to my finding, I have also considered that since the Assessment Contact, the service has responded to the Assessment Team’s findings and have ensured hardcopy documentation is available, in addition to access of this information on the organisation’s electronic platforms.

I acknowledge that staff had participated in PPE training but had not been competency tested prior to the Assessment Contact due to training supplies being unavailable. While staff interviewed were unable to articulate the correct sequence for donning and doffing of PPE, the Assessment Team did not interview clinical staff who are responsible for guidance and support of staff in relation to the use of PPE. Additionally, the Assessment Team did not observe staff perform donning or doffing of PPE during the Assessment Contact. I am satisfied that in the event staff are required to use PPE they would be supported with visual guidance rather than having to remember the sequence from memory. The Approved Provider’s response indicates all staff have been provided with cue cards to support correct sequencing and have also been competency tested in relation to donning and doffing of PPE.

For the reasons detailed above I find Uniting Communities Incorporated, in relation to Murray Mudge, to be Compliant with this Requirement.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.