Rocky Ridge

Performance Report

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**Commission ID:** 6986

**Provider name:** Australian Regional and Remote Community Services Limited

**Assessment Contact - Site date:** 8 September 2020

**Date of Performance Report:** 29 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

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| --- | --- |
| **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 consumers, staff and others
* the provider’s response to the Assessment Contact - Site report received 8 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 assessed as Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant. The Assessment Team assessed Requirement (3)(b) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically in relation to blood glucose level monitoring for diabetic consumers, wound management and chemical restraint processes.

The Assessment Team have recommended Requirement 3(b) 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 Requirement (3)(b) and find the service is 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, the Assessment Team highlighted risks associated with diabetes management, wound documentation and chemical restraint. This was evidenced by the following:

In relation to diabetes management:

The Assessment Team identified three consumers who have not had blood glucose level (BGL) monitoring conducted in line with Diabetic management plans or the service’s process. All three consumers were noted to be non-insulin dependent diabetics. The Assessment Team’s report indicates:

In relation to one consumer

* An Individualised instruction for residents with diabetes form indicates monthly BGL monitoring. A Diabetes management plan indicates monthly BGL monitoring, however, a diabetes management strategy indicates weekly BGLs.
* In the event of hyperglycaemia (high BGLs), instructions direct staff to obtain a full set of observations, a urinalysis, inform the Medical officer where the consumer’s BGL is outside of acceptable range (greater than 15mmol/L) and recheck the BGL within two hours.
* On 29 August at 4.15pm, the consumer was found crawling on the veranda with a temperature and high BGL of 30mmol/L. Observations were conducted, the Medical officer informed, and the consumer transferred to hospital. The consumer returned to the service on 2 September 2020 with the BGL noted to be within acceptable range.
* A BGL of 26.6mmol/L was recorded on 3 September at 9.00pm and was not repeated until 4 September 2020 at 9.40am where it was noted as 19.1mmol/L. The BGL was not retested.
* A BGL of 17.8mmol/L was recorded on 5 September 2020 at 1.10pm. The BGL was not rechecked until 8.00pm.

In relation to one consumer:

* An Individualised instruction for residents with diabetes form dated 26 January 2020 indicates monthly BGL monitoring. A Diabetes management plan dated 29 July 2020 indicates monthly BGL monitoring, however, a diabetes management strategy indicates BGLs are not currently monitored.
* BGLs had not been recorded for April or July 2020.
* A BGL of 18mmol/L was recorded on 28 June at 10.00am. No further action is recorded and the BGL was not repeated until 24 August 2020.
* The consumer was transferred from hospital back to the service on 24 August 2020 at 1.30am. A BGL was recorded as 26.4mmol/L. A further BGL was not repeated until 8.25am (22.5mmol/L) the Medical officer, family and public guardian were informed, and a meeting was held regarding end of life management. A further BGL was taken at 7.45pm (32.2mmol/L). No further action was taken and the BGL was not repeated.
* A BGL of 23.1mmol/L was recorded on 26 August at 8.35am. A BGL was not repeated. A Registered nurse notation on 27 August at 7.14pm indicates BGL to be followed up ‘this pm’. The BGL was not repeated until the next day.
* A BGL of 25.2mmol/L was noted on 28 August 2020 at 9.00am. Phone consultation between the Medical officer, family and public guardian relating to the BGLs was held at 4.02pm and the consumer was transferred to hospital for treatment of high BGLs.

In relation to one consumer:

* A Diabetes management plan indicates twice daily monitoring of BGLs. The consumer had experienced multiple episodes of hypoglycaemia (low BGLs) in July 2020. The service could not provide evidence that BGLs had been obtained since 29 July 2020.
* Clinical staff could not relay frequency of BGL monitoring in line with consumers’ Diabetic management plans.
* In relation to this consumer, staff stated BGLs are monitored when the consumer exhibits symptoms or is Resident of the day, rather than twice a day as directed by the Medical officer.

The approved provider’s response indicated they agreed with the Assessment Team’s findings and have implemented a range of actions in relation to diabetes management. The approved provider’s response indicates:

* For the three consumers identified:
* Reviewed and revised Diabetes management plans. Updated plans were included as part of the approved provider’s response.
* Ensured BGLs have been documented in the record in line with the plan.
* Noted no BGLs have been recorded outside prescribed range for all three consumers since updated care plans were implemented.
* Provided specific education related to diabetes management to all Registered staff. A training attendance record for the 24 September 2020 indicating attendance of three staff was included as part of the approved provider’s response.
* Implemented a program where monitoring of all BGLs across the organisation is being conducted by the Clinical Lead in Diabetes management to highlight gaps and provide feedback to the Service managers where identified.
* Diabetes management has been included in the monthly audit program. Responses to out of range recordings to be noted and presented at monthly organisational Clinical Governance meetings.

In relation to wound management

* Documentation viewed by the Assessment Team demonstrated three chronic leg ulcers were being treated in line with directives. However, wound photos had not been taken since 26 July 2020 and size of wounds had not been documented on the wound chart at the initial assessment or since.

The approved provider’s response indicated they agreed with the Assessment Team’s findings and have implemented a range of actions in relation to wound management. The approved provider’s response indicates:

* Wound management practices reviewed in comparison to best practice.
* Education to Registered staff relating to photographing wounds at each dressing to monitor progress. Evidence of information provided to staff was included as part of the approved provider’s response.
* A directive issued to staff providing guidance relating to expectations for documentation. The Directive was provided as part of the approved provider’s response. Additionally, an audit program against the directive has been implemented.

In relation to chemical restraint

* A restraint authorisation for a consumer receiving psychotropic medication had not been signed by the consumer’s representative and did not include evidence of discussion or outline the risks associated with the use of the chemical restraint.

The approved provider’s response did not address issues highlighted in the Assessment Team’s report relating to authorisations for chemical restraint.

I acknowledge the approved provider’s proactive response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Assessment Contact, the service’s processes relating to management and monitoring of blood glucose levels and wounds was not effective. Additionally, a restraint authorisation did not include sufficient information relating to risks associated with administration of psychotropic medication.

Inconsistent information relating to frequency of blood glucose level monitoring was noted in three consumer files. Two of these consumers were noted to have frequent episodes of high blood glucose levels, however, actions in response to the high readings were not undertaken in line with Medical officer directives or the service’s processes. The service was unable to provide evidence that blood glucose levels had been obtained for one consumer since 29 July 2020 following multiple episodes of low blood glucose level readings recorded in July 2020. Additionally, all three consumers were noted to be non-insulin dependent diabetics.

The Assessment Team’s report includes deficits in relation to wound management for one consumer, such as the size of wounds not being recorded at the initial assessment or ongoing. Additionally, photographs to monitor wound progress had not been consistently taken.

Whilst one consumer had a restraint authorisation in place for psychotropic medication, the authorisation had not been signed by the consumer’s representative and did not outline risks associated with the use of the chemical restraint.

For the reasons detailed above, I find the approved provider, in relation to Rocky Ridge, Non-compliant in relation to 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)**

* Ensure staff have the skills and knowledge to:
* Undertake blood glucose monitoring in line with Medical officer and the service’s directives, including recognising levels outside of acceptable range, implementing appropriate monitoring strategies and contacting Medical officers for further directives as appropriate.
* Undertake wound management in line with the service’s processes, including completing all aspects of charting requirements and photographs to monitor wound progress.
* Complete restraint authorisations in consultation with consumers and/or representatives, ensuring risks associated the use of restraint are discussed and documented.
* Review processes and practices relating to management of diabetes, wounds and use of restraint.
* Ensure policies and procedures in relation to diabetes, wound management and restraint are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies and procedures in relation to diabetes, wound management and restraint, including assessment, reporting and monitoring.