Serene Residential Care Services

Performance Report

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**Commission ID:** 6820

**Provider name:** Blu Dawn Pty Ltd

**Assessment Contact - Site date:** 10 June 2021

**Date of Performance Report:** 25 August 2021

# Publication of report

This Performance Report **will 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)(a) | Non-compliant |
| Requirement 3(3)(b) |  Non-compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(e) | 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 2 July 2021.
* The Performance Report dated 16 March 2021 for the Site Audit conducted 7 December 2020 to 8 December 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 two of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team assessed Requirements (3)(a) and (3)(b) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The service was found Non-compliant with Requirement (3)(a) following a site audit conducted 7 December 2020 to 8 December 2020, specifically in relation to diabetes management. The Assessment Team’s report for the Assessment Contact included evidence of actions taken to address the deficiencies identified which are detailed in the specific Requirement below. However, the Assessment Team were not satisfied that the service had addressed the deficiencies related to diabetes management. Further, the Assessment Team found the service was not able to demonstrate that each consumer gets safe and effective personal clinical care, or both personal and clinical care that is best practice, is tailored to their needs and optimises their health and wellbeing, specifically in relation to pressure injury prevention, wound management, weight management, and falls management. The Assessment Team found that the service was unable to demonstrate effective management of high impact or high prevalence risks in relation to pressure injury and wound management, medication management, and pain management.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 3 Requirements (3)(a) and (3)(b) and find the service Non-compliant with Requirements (3)(a) and (3)(b). The reasons for the finding are detailed in the specific Requirements below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The service was found Non-compliant with Requirement (3)(a) following a site audit conducted 7 December 2020 to 8 December 2020 specifically in relation to the diabetes management for five consumers. The service was unable to provide diabetes management policies and procedures to guide staff in best practice diabetes management to ensure consumer needs are met and health and wellbeing is optimised. Further, consumers did not have individualised diabetes management plans that included target range blood glucose levels or instructions for management of hypoglycaemia or hyperglycaemia.

The service agreed that there were deficiencies in diabetes management at the service and in response to the deficiencies, implemented improvements including (but not limited to):

* All consumers with diabetes were referred to their general practitioner (GP) to include target and reportable blood glucose level ranges and actions required in the event of hypoglycaemic or hyperglycaemic episodes.
* Implemented a diabetic management hypoglycaemic procedure.
* Provided staff training in diabetes management.

At the Assessment Contact, the Assessment Team were not satisfied that the service had addressed the deficits identified in relation to diabetes management. Further, while consumers and representatives interviewed stated that they were satisfied with the care and services provided, the Assessment Team was not satisfied that the service demonstrated each consumer gets safe and effective personal clinical care, or both personal and clinical care that is best practice, is tailored to their needs and optimises their health and wellbeing, specifically in relation to pressure injury prevention, wound management, weight management, and falls management. However the Assessment Team was satisfied that one Consumer’s mobility was appropriately assessed and care was planned that was tailored to their needs. The Assessment team provided the following information and evidence in relation to their recommendation of not-met in this Requirement.

In relation to diabetes management, the Assessment Team found:

* The Assessment Team reviewed the files of five consumers with diabetes, and one consumer (Consumer D) did not have a complete individualised diabetes management plan recorded. Specifically, there was no high range reportable blood glucose level or actions required in the event of hyperglycaemic episodes documented.
* Clinical staff interviewed regarding Consumer D’s diabetes management acknowledged the consumer’s diabetes was unstable and they should have a target range documented and strategies to manage hyperglycaemic episodes should they occur.
* Consumer D’s care plan instructed staff to monitor the consumer’s blood glucose levels three times a day, a half an hour prior to meals. The consumer was interviewed and stated staff do not monitor their blood glucose levels on time, for example, not testing before meals as required, but after meals. The consumer also stated they had to ask staff to test their blood glucose levels.
* A consumer, (Consumer A) did not have their blood glucose levels monitored weekly as instructed by their GP, as no blood glucose levels were recorded between 27 January 2021 and 10 June 2021.
* The Assessment Team observed that the Diabetic Management Hypoglycaemic Management Procedure was available to staff.

In relation to pressure injury prevention and wound management, the Assessment Team found:

* Wound charts for two consumers (Consumer A and C) did not demonstrate best practice wound assessment and management. Specifically, the charts did not demonstrate comprehensive wound assessment documentation, with all characteristics of the wound consistently assessed and documented.
* Consumer A, who experiences diabetes, reduced mobility and stage II pressure injuries, had a skin assessment undertaken in February 2021 and was identified at moderate risk (score 12) of developing pressure injuries using the Norton Risk Assessment tool. The Consumer did not have planned pressure injury prevention strategies implemented. For example, the consumer was assessed as requiring an air mattress, however did not have one in place. Management explained to the Assessment Team, that the Consumer did not like the noise so it was removed.

In relation to weight management, the Assessment Team found that one consumer’s (Consumer A) weight charts indicated they lost 11.9 kg between January 2021 and March 2021, which was not identified, and therefore, not actioned by the service. As such, the service had not:

* Referred Consumer A to a dietician, increased the frequency of weights from monthly to weekly, and commenced the consumer on high energy high protein (HEHP) diet or commenced food and fluid charting in alignment with their Nutrition Hydration and Weight monitoring policy.
* Discussed Consumer A’s weight loss and management with their representative.

The Assessment team found that in addition to Consumer A’s weight loss not being identified in March 2021, their weight was not monitored in April, May or June 2021. Further, the Assessment Team found:

* The service did not demonstrate a process is in place for weighing consumers who are wheelchair bound to ensure weight is monitored.
* The service did not demonstrate an effective process to ensure that consumers who experience weight loss are identified. The Assessment team reviewed the service weight loss reports and identified that these reports were statistical data only, and no analysis or evaluation is recorded to identify consumer with weight loss. Further, the Assessment Team reviewed clinical meeting minutes between 29 January 2021 and 14 May 2021 and no information is recorded related to weight loss.
* The service did not demonstrate an understanding of risks of malnutrition for consumers who unintentionally lose weight but remain in or above the normal weight range. For example, the Assessment Team discussed Consumer A’s weight loss with management and one Registered Nurse. The staff did not consider that the consumer may be malnourished as their weight was within a normal weight range.
* The service Nutrition Hydration and Weight monitoring policy instructs staff to undertake malnutrition screening assessments for consumers. The Assessment team identified that the malnutrition screening was not completed for Consumer A in alignment with the service procedure.

In relation to clinical monitoring, one consumer (Consumer C) did not have their blood pressure monitored daily in alignment with the GP instructions. For example, there was no recorded blood pressure for 6 occasions in a two week period between 31 May 2021 and 14 June 2021.

In relation to falls management, the Assessment Team reviewed the file of one consumer (Consumer B) who had experienced four falls within a three week period and found:

* Two of the four falls had resulted in injuries (skin tears).
* For two of the falls, the service did not undertake clinical observations (neurological observations) in alignment with the service falls management procedure. Only one set of neurological observations were recorded. For one of the four falls, no neurological observations were recorded. There was no documentation in the Consumer’s file that indicated the Consumer’s GP had ceased the clinical observations following the falls.
* The service falls management procedure instructs staff to undertake a falls risk assessment (FRAT) if a consumer experiences two or more falls within seven days, and/or three or more falls in one month.
* The service falls management procedure instructs that consumers are to be reviewed by a physiotherapist following falls. The Assessment Team found that Consumer A was reviewed by a physiotherapist two weeks after their fourth fall had occurred.

The provider submitted a response to the Assessment Team’s report which addressed deficits identified in the Assessment Team report and provided a plan for continuous improvement. The provider’s response included, but was not limited to:

In relation to diabetes management, the provider agreed that one of the five consumer files reviewed did not have an individualised diabetes management plan documented, however stated this was an isolated case as all other consumers had management plans recorded. Further, in relation to Consumer D, the service provided BGL monitoring charts to demonstrate strict monitoring of blood glucose levels in alignment with the direction of the GP (three times per day, half an hour prior to meals).

In relation to pressure injury prevention and wound management, the service:

* Provided wound assessment and management plans for Consumer A to demonstrate that wound characteristics are assessed and documented.
* Provided education to all clinical staff regarding wound documentation on 2 July 2021.

In relation to weight management the provider agreed that Consumer A’s weight loss should have been identified and actioned and consumer’s nutritional risk assessment should have occurred. The service actioned a dietician referral and the Consumer was reviewed. All staff at the service have undertaken a training session and been reminded of their responsibilities to manage weight loss in consumers.

The provider disagreed that one consumer did not have their blood pressure monitored on the six occasions identified by the Assessment Team, and advised that the information was recorded in another location, and stated that the blood pressure had been taken but not recorded on two occasions.

In relation to falls management, the provider advised that of the three falls where inadequate neurological observations occurred, two falls were witnessed falls, and ongoing neurological observations were not required, and the third fall was a roll out of bed onto a crash mat and was not considered a fall. The service provided the incident forms in support of their response. The service provided mandatory training to all clinical staff related to the service post falls management procedure, including (but not limited to) the frequency of neurological observations required.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the evidence provided by the service in response to the Assessment Team’s report. Based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact the service was unable to demonstrate that each consumer gets safe and effective personal clinical care, or both personal and clinical care that is best practice, is tailored to their needs and optimises their health and wellbeing. The reasons for my finding are detailed below.

In relation to diabetes management, diabetic management plans did not reflect or promote best practice as not all consumers had a comprehensive individualised diabetes management plan that included target and reportable blood glucose level ranges and actions required in the event of hypoglycaemic and hyperglycaemic episodes. While the provider asserts that this was an isolated case, the consumer who did not have a complete diabetes management plan experiences unstable diabetes and requires insulin. Further the blood glucose monitoring charts provided by the provider in relation to Consumer D showed that the service did not consistently monitor Consumer D’s blood glucose levels in alignment with the GP instructions. For example, in a 20 day period between 22 May 2021 and 10 June 2021 there were seven gaps in the charting that covered a mealtime period.

In relation to wound assessment and management, I have considered the service response and the documentation provided in support of their response. The documentation related to Consumer A did not demonstrate ongoing wound assessment documentation for each wound that reflects best practice. For example, wound charts for Consumer A documents more than one wound per chart which does not demonstrate understanding of wound management that promotes continuity of care, delivery and the ability to determine if the wound care delivery is effectively meeting the goals of wound care. Further the assessments do not consistently assess and document dimensions of wound e.g. length, width, depth, clinical characteristics of the wound bed, wound edge appearance, peri-wound appearance, exudate type, consistency, amount and colour, odour/infection, inflammation and wound pain. Wound photographs used to support the wound assessment and monitoring did not contain a ruler to assist with wound size assessment and identification of the consumer and wound.

In relation to falls management I have considered the service response and the documentation provided in support of their response. The Assessment Team found that the service had not undertaken clinical observations (neurological) for three of four falls experienced by Consumer B in alignment with the service procedure. The service explained that two falls were witnessed, however the incident forms provided by the service in relation to the falls document that one of the falls was unwitnessed and as such, the service had not undertaken the required post fall clinical observations. The service response stated that they did not consider a roll out of bed a fall, and completed an incident form only as the Consumer experienced an injury (skin tear) from the roll out of bed. Further, the incident forms do not indicate investigation of the cause of falls or evaluation of the current falls prevention strategies in place. The falls management procedure at the service does not consider falls risk assessments occurring following falls (as new risk factors may be present), rather the service undertakes falls risk assessments following two or more falls within seven days and/or three or more falls in a month. This does not demonstrate that the service understands best practice falls management, including (but not limited to) what constitutes a fall, monitoring and investigating falls, completing falls risk assessments following falls in order to plan and implement standardised and individualised fall prevention and injury minimisation strategies to optimise the health and wellbeing of consumers.

For the reasons detailed above, I find Blu Dawn Pty Ltd in relation to Serene Residential Care Service, Non-compliant with Standard 3 Requirement (3)(a).

### 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 risks associated with pressure injury management, wound management, medication management and pain management. The Assessment team provided the following information and evidence relevant to my finding:

In relation to pressure injury and wound management, the Assessment Team found that two consumers did not have wounds managed effectively. For one consumer (Consumer C), a pressure injury was not identified in a timely manner, as when it was first identified, it was a necrotic wound. Further, pain associated with the wound was not managed effectively, and the assessment and documentation of the wound did not promote effective wound management. Specifically:

* An Enrolled Nurse documented in the progress notes that a necrotic pressure injury was identified on the right heel of Consumer C on 1 June 2021. They stated the wound had developed in hospital. However, a hospital discharge letter dated 28 May 2021 did not include the presence of a pressure injury, and progress notes do not record changes in skin integrity between 28 May 2021 and 1 June 2021.
* While the pressure injury was identified as a necrotic injury on 1 June 2021, the assessment and care panning by the Enrolled Nurse was inconsistent, a review by a Registered Nurse was not completed until 3 June 2021, an incident form was not completed until 4 June 2021, and a review by the GP was not undertaken.
* The Assessment Team reviewed wound management plans between 1 and 10 June 2021 and found the charts did not demonstrate comprehensive wound assessment, with all characteristics of the wound assessed and documented, and there was no description regarding the progress of the wound or the designation of the staff member attending to the wound.
* The Assessment Team viewed an undated photograph of the heel, which indicated a black area 7cm x 2-3 cm and depth of the wound could not be determined.
* The Assessment Team found that Consumer C required analgesia associated with the pressure injury on 8 June 2021 however no pain assessments related to wound pain was included in Consumer C’s documentation reviewed between 1 and 10 June 2021.

The Assessment Team found that for another consumer (Consumer A) their wounds were not managed effectively as:

* A skin Assessment dated 26 December 2020 identified 16 wounds.
* The Assessment Team reviewed wound charts between 28 December 2020 and 13 May 2021 and found charts that included more than one wound per chart, multiple wound names/sites and the progression of the wounds was difficult to follow.
* The Assessment Team found that Consumer A’s wounds had become infected and necrotic on 13 May 2021, however the Assessment Team was unable to determine which wounds were infected or necrotic, as the wound chart referred to two wounds on the one chart.
* No referral to a wound specialist had occurred.

In relation to medication management, the Assessment Team found that the service had not demonstrated effective management of risks related to medication management for one consumer (Consumer C) who experienced dysphagia (difficulty swallowing). Specifically:

* Consumer C’s medication chart dated 31 May 2021 documented the consumer required their medicines crushed, however progress notes dated 4 June 2021 documented that the Consumer was having difficulty swallowing whole (uncrushed) medicines.
* Clinical Staff interviewed regarding the care of Consumer C, were unaware if the Consumer had been referred to a speech pathologist following identification of their difficulty swallowing medicines.

In relation to pain management, the Assessment Team found that for one consumer (Consumer A) their pain was not effectively assessed or managed. Specifically:

* Pain assessment charting was inconsistent, as the Assessment Team found multiple charts with overlapping time periods and the charts were incomplete.
* While there were 42 entries in the progress notes which indicated the consumer was in pain, with the exception of ongoing use of PRN (as required) medication which provided short term relief, the service was unable to demonstrate they identified the Consumer’s increasing pain in a timely manner or an effective review of the pain. The consumer continued to experience ongoing episodes of pain.
* There were a further 36 entries in the progress notes between 11 April to 10 June 2021 related to agitation, aggression or restlessness where benzodiazepines (including oxazepam and midazolam) were administered. The Assessment Team found:
* Of the 27 occasions when benzodiazepines were administered in response to agitation and aggression, 26 did not document alternative strategies trialled prior to administration, such as pain management or other strategies.
* On one occasion analgesia was administered however no other information was recorded.
* The Assessment Team discussed Consumer A’s pain management who stated that their pain had been managed well, as they were reviewed weekly by their GP and changes made to their analgesia prescriptions.

The provider submitted a response to the Assessment Team’s report which addressed deficits identified in the Assessment Team report and provided a plan for continuous improvement. The provider’s response included, but was not limited to:

* In relation to Consumer A’s pressure injury:
* Advised that Consumer C returned to the service from hospital with a pressure injury (blood blister, unbroken skin) to the heel.
* Provided medical notes for 11 June 2021 which documented that the pressure injury was reviewed by the GP on 5 June 2021, however they did not document they had reviewed the wound on that date.
* Considered that staff should have undertaken a full skin assessment for Consumer C when they returned from hospital, however there was no specific procedure at the service. As such the service has implemented a new procedure clarifying the assessments required when consumers return from hospital. All clinical staff have undertaken mandatory training in relation to this procedure.
* Charts relating to resolved wounds have been archived to reduce confusion over wound management documentation.
* Provided wound assessment and management plans for Consumer A to demonstrate that wound characteristics are assessed and documented.
* Mandatory education on skin assessment and wound documentation was conducted for all clinical staff on 2 July 2021.
* In relation to Consumer A, acknowledged the lack of pain assessment and evaluation and conducted mandatory education on pain assessment for all clinical staff. Further, a referral has been made to a pain clinic and Dementia Support Australia in relation to pain and responsive behaviours.
* Explained that in relation to Consumer C, it is best practice to not crush medications unless there is an assessed need, and medications can be downgraded to crush without a speech pathologist review.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the evidence provided by the service in response to the Assessment Team’s report. Based on the Assessment Team’s report and the provider’s response, I find the service has not demonstrate that effective management of high impact or high prevalence risks associated with the care of each consumer. Specifically, in managing risks associated with pressure injuries, wound management, medication management and pain management. The reasons for my finding are detailed below.

In relation to pressure injury and wound management, I have considered the service’s response and the documentation provided in support of their response. The service explained that Consumer C’s pressure injury was a blood blister, acquired in hospital and provided the medical notes relating to Consumer’s C’s medical reviews. The GP recorded on 11 June 2021 the pressure injury was an ‘area of dark brown to black’, and ‘skin intact’. However, according to the Assessment Team report, service documentation stated the pressure injury was necrotic on identification on 1 June 2021 and viewed an undated photograph of the wound, in which the wound was black, 7cm x 2-3 cm and depth could not be determined. In coming to my finding, I have considered that the service has not been able to demonstrate effective pressure injury management as effective management requires timely, accurate and comprehensive injury identification, staging and assessment, in order to plan appropriate pressure area care. It is unclear if the pressure injury is a Stage II (blister), deep tissue injury or unstageable injury. Further in relation to wound management the service did not demonstrate that accurate or comprehensive wound assessment documentation promotes the safety, continuity of care delivery and the ability to determine if the management plan is effectively meeting the goals of wound care for two consumers. In addition, the wound was not assessed by a Registered Nurse in a timely manner, the incident not reported in a timely manner and pain associated with the wound was not effectively assessed or managed.

In relation to medication management, I consider that at the time of the Assessment Contact, the service was unable to demonstrate effective medication management for one consumer who experienced dysphagia as instructions to staff were inconsistent, and there was no consideration of a referral to a Speech Pathologist when staff observed swallowing difficulties with medicines.

In relation to pain management, the service has acknowledged the deficits relating to pain assessment and management and provided mandatory education to clinical staff regarding pain assessments. However I find that at the time of the Assessment Contact, the service was unable to demonstrate that Consumer A’s increasing pain was effectively identified and managed. In addition, staff at the service did not demonstrate consideration of pain as a trigger for Consumer A’s responsive behaviours or trial alternative strategies prior to the administration of benzodiazepines.

For the reasons detailed above, I find Blu Dawn Pty Ltd in relation to Serene Residential Care Service, Non-compliant with Standard 3 Requirement (3)(b).

# STANDARD 7 Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(e) in relation to Standard 7. All other Requirements in this Standard were not assessed. Therefore, an overall rating of the Standard is not provided.

The service was found Non-compliant with requirement (3)(e) following a site audit conducted 7 December 2020 to 8 December 2020 in relation to the regular assessment, monitoring and review of the performance of each member of the workforce. Specifically, the service was unable to demonstrate that all staff had participated in performance reviews in the previous two years, or end of probationary period performance reviews for new staff. The Assessment Team’s report for the Assessment Contact include evidence of actions taken to address deficiencies identified which are detailed in the specific Requirement below.

The Assessment Team have recommended Requirement (3)(e) as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 7 Requirement (3)(e) and find the service Compliant with Requirement (3)(e). The reasons for the finding are detailed in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken*

The service was found Non-compliant with Requirement (3)(e) following a site audit conducted 7 December 2020 to 8 December 2020, in relation to regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The Assessment Team’s report provided evidence of actions taken to address the deficiencies identified, including, but not limited to:

* All staff performance and development reviews (annual and probationary) were conducted.
* Implemented a new Employee Feedback and Training Needs Analysis in order to identify learning needs to inform training schedules for staff. All staff completed the form in December 2020 and collated into the development of the 2021 training schedule.
* Administration officers monitor the mandatory and optional training completed by staff.

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

* Five clinical and care staff interviewed were able to discuss the performance review process, including their participating in annual and probationary performance reviews. In addition, clinical staff described training has been included in all staff and clinical meetings.

* The Assessment Team reviewed records that demonstrated the ongoing performance assessment and review of service employees.
* The Assessment Team sampled four staff files which demonstrated performance reviews were conducted in alignment with the service’s procedure.
* The service was able to demonstrate the Employee Feedback and Training Needs Analysis and how it informed training needs for staff. In addition, management described how clinical incident reviews and clinical auditing informed training needs and performance review processes. The Assessment team reviewed one incident report and one complaint that demonstrated the service using this information to improve care delivery.

The provider did not submit a response to the Assessment Team’s report in relation to this Requirement.

In coming to my finding, I have considered the evidence documented in the Assessment Team’s report. Based on the information provided to the Assessment Team through staff interviews, observations and documentation sampled, I consider that the service has demonstrated that they undertake regular assessment, monitoring and review of the performance of each member of the workforce.

For the reasons detailed above, I find Blu Dawn Pty Ltd in relation to Serene Residential Care Service, Compliant with Standard 7 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.

* Ensure the service has diabetes management policies and procedures that align with best practice and includes adequate guidance to staff regarding management of hypoglycaemia, hyperglycaemia and sick day management.
* Ensure that each consumer with diabetes has a diabetes management plan that aligns with best practice and includes (but not limited to) individualised target range, management of hypoglycaemia, hyperglycaemia and sick day management.
* Ensure that each consumer with diabetes has their blood glucose monitored and documented in alignment with their diabetes management plan.
* Ensure registered nurses undertake consistent, accurate and comprehensive wound care documentation that aligns with best practice wound assessment and documentation, to promote continuity of care, and the ability to determine if the wound care delivery is effectively meeting the goals of wound care. Consider how registered staff will meet their responsibilities for comprehensive wound assessment and documentation utilising the service chart which may limit selection options.
* Ensure that the service has wound management policies and procedures in place that reflect best practice wound management, including (but not limited to) roles and responsibilities of clinical staff in relation to managing wounds that considers their scope of practice and when referral to a wound specialist may be required.
* Ensure the service has an understanding of what constitutes a fall.
* Ensure than when consumers fall, staff undertake initial and ongoing clinical assessments that align with best practice falls management recommendations
* Ensure than when consumers fall, the consumer is re-assessed, falls are reported and investigated such that falls risk factors are identified and managed.
* It is recommended that the service considers governance process in place to ensure staff appropriately implement policies and procedures.
* Ensure that clinical staff have the skills and knowledge to accurately identify and stage pressure injuries.
* Ensure that service staff report incidents in a timely manner.
* Ensure staff at the service have an understanding of risks to consumers in relation to dysphagia.
* Ensure the service has a process in place for timely referrals to specialist’s services, such as allied health and dementia support.
* Ensure staff at the service understand behaviour management, including consideration of pain as a trigger in responsive behaviours.
* Consider reviewing behaviour management and restrictive practice processes at the service, to ensure compliance with responsibilities.
* Ensure staff at the service utilise validated pain assessment tools and understand how to appropriately complete, including frequency of assessments required and documentation of the assessments, action taken and evaluation of the actions taken.
* Ensure that the service has a system in place to review consumer’s pain management and identify increasing pain in a timely manner.