SummitCare Wallsend

Performance Report

7 Bent Street   
Wallsend NSW 2287  
Phone number: 02 4944 1500

**Commission ID:** 0841

**Provider name:** Stelcom Pty Limited

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

**Date of Performance Report:** 2 February 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

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| --- | --- |
| **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 provider’s response to the Assessment Contact - Site report received 13 January 2021.

# 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Overall, sampled consumers are satisfied with the care they receive. The Assessment Team noted that there are deficits in the service’s documentation of clinical monitoring and psychotropic medication. The provider submitted further evidence to dispute some of these findings, although they have acknowledged some of their documentation is inconsistent. However, they have demonstrated that effective care has still been provided to consumers in each instance.

The Assessment Team also noted the service was able to demonstrate appropriate practices around antibiotic prescribing. However, they demonstrated gaps in practices regarding their standard and transmission-based precautions for infection. The provider has since submitted further evidence to satisfactorily demonstrate that they are able to minimise infection related risks.

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

### 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.*

The Assessment Team reviewed clinical documents for three consumers and identified inconsistent documentation regarding their clinical monitoring charts. The deficits found were in urinalysis, wounds, daily temperatures, daily pulse, patch application and sight charts. For wound care, the team also noted that the wound care instructions were not accurately followed or reflected in documentation. Additionally, the team found that psychotropic medication and authorisation forms were not reviewed on a regular basis by the medical officer and representatives.

The Assessment Team interviewed the manager of Clinical Care who noted that there were previously identified deficits with their management of high impact or high prevalence risks (wound management) and the service is currently in the middle of addressing them. For example, a registered nurse had been rostered 3 days per week to review all complex wounds and improve the service’s wound management. A wound consultant has also commenced and reviews all wounds on a regular basis, and there has been a notable decrease in major/complex wounds as a result.

The Assessment Team also interviewed the sample of consumers, who were generally satisfied with their care and reported it as ‘good’.

Based on their findings, the Assessment Team had recommended this requirement to be not met.

The provider has since responded to these findings. The provider has disputed some observations made by the Assessment Team. For example, they have provided further evidence to explain that wound care instructions were accurately followed, psychotropic medication and authorisation forms are reviewed regularly, and that care had been adequately delivered for each consumer. However, the provider acknowledges that that the Assessment Team correctly identified inconsistencies in their documentation which requires improvement.

I have evaluated the above findings and provider response in relation to this requirement. I have considered whether the deficits in documentation identified have (or will eventually have) meant high impact and prevalent risks of each consumer is not effectively managed. After careful consideration, I am unable to support this conclusion. The sampled consumers have stated they receive ‘good care’, and the provider was able to demonstrate the consumers had positive clinical outcomes with no harm identified. I believe this indicates the high impact risks associated with the care of each consumer are effectively managed, although I note that the provider will need to improve in their area of recording documentation consistently.

Based on the evidence (summarised above), I find this requirement compliant as the provider can demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

### 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 interviewed staff whom were able to describe their approach to minimising risk of infection and reducing the use of antibiotics. Staffing records also confirmed 100% of staff have completed their handwashing competencies, with 89% of staff having completed a second round of donning/doffing competencies.

The Assessment Team reviewed the documents made available by the provider to manage infection related risks. They identified an antimicrobial stewardship policy and infection control policy. They also identified outbreak management boxes which contained documentation, signage, COVID-management plans, and other tools to manage an outbreak. However, the Assessment Team reported gaps in the outbreak management plan, for example, they were unable to find a list of staff with clear roles and responsibilities during an outbreak. They also stated to have found deficits in daily monitoring of a consumer’s temperature, which would affect the service’s ability to recognise and contain outbreaks early.

The Assessment Team made observations at the service and noticed that most staff wore masks correctly, although four staff were observed to wear masks incorrectly. On one occasion, staff were also observed to breach social distancing requirements and sat closely together at a dining table.

Based on their findings, the Assessment Team had recommended this requirement to be not met.

The provider has since responded to these findings. They have evidenced that the gaps identified by the Assessment Team regarding the outbreak management plan were not present. For example, they have submitted a poster which documents the list of staff with clear roles and responsibilities during an outbreak. Accompanying this poster, they have submitted an onsite Infection Control audit report from NSW Health completed on 23 Oct 2020, which support that this document (and others) were already existing prior to the audit.

With regard to the staff who did not adhere to correct social distancing and mask use, the service notes that feedback has been provided to the staff. The service explains that they have over 100 staff and these were isolated incidents, as most staff were observed by the Assessors to be compliant with mask use and social distancing. The service highlights they had successfully contained a rhinovirus outbreak prior to their audit in Oct 2020, and passed an onsite NSW Health Infection Control audit, which demonstrates their capacity in practice to manage and minimise infection related risks.

With regard to the observation that some daily temperature of consumers were not taken and recorded, the provider notes that the resident temperatures were actually recorded and reported, but noted on the handover sheet rather than their electronic system. The provider acknowledges the method of documentation was inconsistent and will address this issue.

I have considered the above evidence, and I am satisfied with the provider’s response to the Assessment Team’s findings. I find this requirement compliant, as the service can demonstrate minimisation of infection related risks through implementing standard and transmission based precautions, and practices to minimise antibiotic use.

# 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.