Terrace Gardens

Performance Report

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**Commission ID:** 6988

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

**Assessment Contact - Site date:** 1 September 2021

**Date of Performance Report:** 21 October 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 1 Consumer dignity and choice** |  |
| Requirement 1(3)(c) | Compliant |
| **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 Approved Provider’s response to the Assessment Contact - Site report received 27 September 2021.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Assessment Team assessed Requirement (3)(c) in Standard 1 Consumer dignity and choice as part of the Assessment Contact and have recommended this Requirement as met. All other Requirements in this Standard were not assessed. Therefore, an overall rating of the Standard has not been provided.

I have considered the Assessment Team’s findings and evidence documented in the Assessment Team’s report and based on this information, I find Australian Regional and Remote Community Services Limited, in relation to Terrace Gardens, to be Compliant with Requirement (3)(c) in Standard 1 Consumer dignity and choice. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers and representatives sampled confirmed consumers are supported to exercise choice and independence.
	+ Three consumers/representatives described how consumers are supported by staff to maintain their independence and make choices.
* Staff interviewed were able to describe how they support consumers to exercise choice, including providing specific consumer examples and how they use care plans to understand consumers’ preferences and decisions.
* Consumers’ care documentation demonstrated staff have consulted with consumers in relation to who is involved in their care planning and decision making. Care plans also included consumers’ personal preferences.
* For the reasons detailed above, I find Australian Regional and Remote Community Services Limited, in relation to Terrace Gardens, to be Compliant with Requirement (3)(c) in Standard 1 Consumer dignity and choice.

# 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 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 at this Assessment Contact.

The Assessment Team have recommended Requirement (3)(b) in this Standard as not met. The Assessment Team found that while most sampled consumers consider they receive personal care and clinical care which is safe and right for them, the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. This finding specifically related to skin and wound care for three consumers. The Approved Provider submitted a response to the Assessment Team’s report and respectfully disagrees with the Assessment Team’s findings.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Australian Regional and Remote Community Services Limited, in relation to Terrace Gardens, to be Non-compliant with Requirement (3)(b) in this Standard. I have provided reasons for my finding 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 while most sampled consumers consider they receive personal care and clinical care which is safe and right for them, the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. This finding specifically related to skin and wound care for three consumers. The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding:

* A consumer (Consumer A) informed the Assessment Team they had a catheter inserted on 12 August 2021 which had been infected since returning from hospital, indicating the insertion site was red, weeping pus and that they must remind staff to re-dress the insertion site. Consumer A also indicated staff had not applied a dressing the previous day, leaving the site undressed for 48 hours and if staff were not going to re-dress the site, they would prefer to do it themselves.
	+ Consumer A’s care plan did not include any information or guidance for staff in relation to monitoring or care of the catheter insertion site. The handover sheet also did not refer to the correct catheter type.
	+ The medical officer reviewed Consumer A on 19 August 2021 and the catheter insertion site was noted to be red, bloody and with purulent discharge. A swab of the site was taken and resulted in Consumer A being prescribed antibiotics which were completed on 1 September 2021.
	+ Progress notes demonstrate the catheter insertion site was dressed inconsistently. The notes showed the site was dressed on three occasions in an eight day period from 23 to 30 August 2021, but on one occasion it was left undressed. A clinical staff member confirmed staff should be dressing the catheter insertion site.
	+ One clinical staff member interviewed was unaware that Consumer A’s catheter insertion site was infected.
* Consumer A informed the Assessment Team they have a pressure area on their sacrum which had not been dressed for 48 hours, with staff applying cream. They also reported their sleeping position is not changed overnight.
	+ A pressure injury risk assessment dated 23 August 2021 indicated the consumer was at high risk but the risk score had been incorrectly calculated and the consumer should have been assessed at very high risk.
	+ Consumer A developed a hospital acquired pressure injury which was identified on 12 August 2021 and triggered a care plan update relating to pressure relieving strategies, which included a foam mattress, monitoring bony prominences, transfer to a wheelchair during the day and four-hourly repositioning. Care and clinical staff interviewed were aware of these strategies.
	+ While Consumer A’s pressure injury wound care was to be undertaken every five days, progress note entries from 13 to 23 August 2021 did not demonstrate this occurred.
* Progress notes indicate a consumer’s (Consumer B) pressure injury wound was not dressed daily in accordance with the medical officer’s directives outlined in the wound and skin care plan, including only being re-dressed once in accordance with the medical officer’s prescribed wound regime in a 13-day period. Additionally, the wound demonstrated signs of deterioration following this period of the wound not being re-dressed daily but was not escalated to the medical officer for further review.
	+ Wound documentation for Consumer B was inconsistent and unclear, with photographs taken at varying angles and measurements not always included.
	+ While the consumer was reviewed by a dietitian on several occasions while having pressure injuries and ongoing weight loss, considerations of dietary and supplement strategies to aid wound healing were not considered until the pressure injury wound had significantly deteriorated. Management indicated supplements to aid wound healing could have been commenced earlier.
* A consumer (Consumer C) had a stage II pressure injury first identified two days prior to the Assessment Contact on 30 August 2021.
	+ A skin assessment had not been completed following this change to Consumer C’s skin integrity.
	+ A clinical staff member indicated staff are aware of strategies to minimise Consumer C’s risk of skin injuries and the pressure injury should have been identified earlier.
	+ The incident report for the pressure injury did not include preventative or corrective actions or confirmation of use of open disclosure. However, Consumer C’s representative confirmed staff had reported the pressure injury to them on the day it was identified.
* The wound management pathway does not direct staff in relation to minimum standards or consistency in relation to wound care documentation.

The Approved Provider submitted a response to the Assessment Team’s report and respectfully disagrees with the Assessment Team’s findings and recommendation of not met. The Approved Provider asserted the service takes the effective management of high impact or high prevalence clinical risks very seriously and has policies, protocols, flow charts and education programs to support staff to identify and manage these risks, including risks related to pressure injury prevention and wound management. The Approved Provider described their partnership and support from wound care specialists and institutes to provide education and support to their staff in relation to wound management and best practice care. While the Approved Provider acknowledges there are some issues with wound care documentation processes and compliance with the use of tape measures in photographing wounds, these are compounded by the use of the electronic care system. However, the Approved Provider asserts clinical staff are providing wound care in accordance with wound care plans and escalating concerns to medical officers and wound specialists appropriately. The Approved Provider submitted the following evidence and information relevant to my finding:

* In relation to Consumer A’s catheter insertion site:
	+ Progress notes shows there was daily monitoring of the catheter insertion site and there was an escalation to the medical officer when possible infection was identified.
	+ Progress notes show Consumer A was readmitted to hospital from 19 to 23 August 2021, following returning to service post the catheter insertion on 12 August 2021.
	+ While the Assessment Team find the catheter insertion site did not have a dressing applied for 48 hours, the Approved Provider asserts documentation supports that on 30 August 2021 the site did have a dressing, indicating the insertion site was dressed.
	+ The consumer has been reviewed by the continence/stomal therapy clinical nurse consultant following the Assessment Contact and staff are guided on the management of the stoma site by this consultant.
* In relation to Consumer A’s pressure injury:
	+ The pressure injury was first identified on the consumer’s second return to the service from hospital on 23 August 2021. Therefore, the Assessment Team’s finding that wound care was not attended between 13 and 23 August 2021 is incorrect. The Approved Provider asserts Consumer A had their pressure injury correctly identified and managed but to improve documentation have reviewed the wound assessment and documentation protocol and circulated documentation requirements and standards to all registered clinical staff.
* In relation to Consumer B:
	+ While the pressure injury was reviewed regularly by the medical officer, the wound was dressed in accordance with the wound care nurse practitioner’s (WCNP) directives, who reviewed the wound in October 2020, January 2021, February 2021, March 2021. A referral to the WCNP was made in May 2021 but a decision was made with the family to send the consumer to hospital.
	+ The consumer’s wound was referred and escalated to the WCNP and medical officer when it was noted to have deteriorated.
	+ The dietitian was regularly reviewing the consumer to implement strategies to maintain their weight and while advice could have included supplements to aid wound healing, the primary concern was weight loss in the context of diabetes control and renal failure.
* In relation to Consumer C:
	+ The consumer has extremely fragile skin and multiple wounds which are being managed in accordance with wound care plans directed by the WCNP.
	+ Clinical staff assessed, photographed and updated the wound management plan when the pressure injury was first identified on 30 August 2021.
	+ Progress notes demonstrate the consumer’s representative was aware of the wound, however, the clinical staff member responsible for completing the incident report has been provided feedback and counselling about correct procedures.
	+ The information provided by a clinical staff member that the pressure injury should have been identified earlier is controversial given the fragility of the consumer’s skin, comorbidities and immobility. The Approved Provider sited evidence that pressure injuries can form at higher levels than a stage one within hours.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

I acknowledge that the Approved Provider has asserted that the service has policies, protocols, flow charts and education programs to support staff, including access to wound care specialists and the improvement actions since the Assessment Contact, including reviewing the wound assessment and documentation protocol and circulating wound documentation standards to clinical staff. However, I find that at the time of the Assessment Contact, the service did not demonstrate effective management of the risks associated with Consumer A’s catheter insertion site nor the risks associated with Consumer B’s pressure injury wound.

In coming to my finding in relation to Consumer A, I have considered that the service has not demonstrated it has effectively managed risks associated with the consumer’s catheter insertion site by not acting on risks/signs of infection in a timely manner, not effectively implementing interventions to prevent infection of the catheter insertion site or not implementing management plans to support daily care and minimisation of risks associated with the catheter.

* In relation to not acting on risks/signs of infection, I have considered that Consumer A’s care plan did not include any information or guidance for staff in relation to the monitoring or care of the catheter insertion site when they returned to service on 12 August 2021, following surgery for the catheter insertion. While progress notes submitted by the Approved Provider demonstrate staff identified redness at the insertion site on 15 August 2021 and that it was be followed-up by the medical officer for further management, the review by the medical officer was not conducted until four days later on 19 August 2021. At the review on 19 August 2021, the medical officer observed the insertion site was red with bloody/purulent discharge and queried the presence of a post-operative infection. The medical officer returned the consumer back to hospital on the advice of the relevant surgical specialist that day, with the consumer returning to the service on 23 August 2021.
* In relation to not effectively implementing interventions to prevent infection at the insertion site, the progress notes submitted by the Approved Provider indicated staff did not ensure post-operative/prophylactic antibiotics to minimise risk of infection were administered to consumer. The medical officer note dated 19 August 2021 indicates that due to documentation difficulties, antibiotics which should have been administered to Consumer A on their return from hospital on 12 August 2021, were not administered until 16 August 2021. I consider this omission of antibiotics has not supported effective management of post-operative infection risks associated with the catheter insertion operation. I have also considered Consumer A’s feedback to the Assessment Team which included that the catheter insertion site has been infected since returning from hospital and that the insertion site was red, weeping pus and that they must remind staff to re-dress the insertion site.
* In relation to not implementing management plans to support daily care of the catheter to minimise risks associated with medical devices, I have considered Consumer A’s care plan did not include any information or guidance for staff in relation to monitoring or care of the catheter insertion site. Additionally, progress notes do not support consistent care or monitoring of the insertion site, with the site re-dressed on three occasions in an eight day period. While the Approved Provider asserts documentation does support the dressing at the catheter insertion site was not omitted for 48 hours, I have relied upon the consumer’s feedback stating the site had not been dressed from the previous day and that they had to remind staff to re-dress the site. I have also considered the progress notes which do not demonstrate the catheter insertion site was consistently dressed with most entries indicating the dressing was found to be wet, indicating the need for more regular dressing changes than was recorded in the progress notes. I have also considered the Approved Provider submitted the review undertaken by the continence/stomal therapy clinical nurse consultant on 3 September 2021, two days after the Assessment Contact. This review indicates the consultant observed the catheter tubing to unsecured and skin around the insertion site to eroded through the tubing putting pressure on the skin due to being unsecured. The consultant also found the catheter insertion site to be red and sloughy and encouraged staff to clean the site twice daily and recommended a dressing. I consider this review indicates staff had not effectively managed the catheter insertion site by not securing the associated tubing, exposing the surrounding skin to risk of breakdown, which has occurred. I also consider the recommended dressing regime indicates staff were not sufficiently monitoring or attending to the dressing at a frequency to support effective care of the catheter insertion site.

In coming to my finding in relation to Consumer B, I have considered that the service has not demonstrated that staff were completing wound care in accordance with the WCNP’s directives to support minimisation of risks associated with chronic pressure injuries. I acknowledged the information and evidence submitted by the Approved Provider demonstrates staff should have been conducting wound care in accordance with the WCNP’s directive, rather than the medical officer as highlighted by the Assessment Team. However, based on the evidence presented by the Approved Provider I consider since January 2021 there were at least four occasions where Consumer B’s pressure injury wound was not redressed in accordance with the frequency directed by the WCNP. I have also considered that in 13-day period in April 2021 the consumer’s wound was not dressed with products in accordance with the WCNP directives. Additionally, wound care documentation did not support effective monitoring of the wound, with photographs taken at varying angles and measurements not always included, and the wound management pathway does not direct staff in relation to minimum standards or consistency in relation to wound care documentation.

While I acknowledge clinical staff had the wound regularly reviewed by the medical officer and WCNP, I consider consumers should expect that clinical staff implement recommendations from specialists with precision and accuracy to minimise risks associated with wounds, such as deterioration and infection. I consider that recommendations were not always effectively implemented or the wound effectively monitored by staff in relation to Consumer B. Additionally, I have considered that the consumer’s nutritional risks were acknowledged by the Approved Provider. While the Approved Provider asserts the dietitian’s focus was on weight maintenance in the context of diabetes control and renal failure, I find the service has not considered the nutritional risks impact on the deterioration pressure injury wound by not considering supplements to aid wound healing.

In relation to Consumer C, I consider staff have responded appropriately when a pressure injury was first identified, including conducting assessments, completing wound charts and updating the care plan to include pressure area care strategies, which staff interviewed were able to describe. The Approved Provider asserts the clinical staff member that said the pressure injury should have been identified earlier is controversial given the fragility of the consumer’s skin, comorbidities and immobility and sited evidence that pressure injuries can form at higher levels than a stage one within hours. However, I consider based on the consumer’s immobility and presumed required assistance with transfers and personal care, there is an opportunity for the service to review their skin monitoring processes for consumers who present with risks of pressure injuries to ensure any changes in skin integrity are identified, maximising the opportunity for stage I pressure injuries to be identified and requisite changes to care initiated.

For the reasons detailed above, I find Australian Regional and Remote Community Services Limited, in relation to Terrace Gardens, to be Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

# 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.

* In relation to Standard 3 Requirement (3)(b) the service should seek to ensure:
	+ Consumers’ high impact or high prevalence risks associated with their care are effectively managed. Specifically risks associated with skin and infections relating to the insertion of medical devices and management of chronic wounds for consumers with complex health needs, including consideration of risks impacting wound healing, accurate implementation of wound specialist recommendations and accurate and consistent wound care documentation.