Performance

Report

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| Name: | HammondCare Scarborough |
| Commission ID: | 1006 |
| Address: | 19 Kiama Street, Miranda, New South Wales, 2228 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 25 June 2024 |
| Performance report date: | 24 July 2024 |
| Service included in this assessment: | Provider: 749 HammondCare  Service: 6810 HammondCare Scarborough |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for HammondCare Scarborough (**the service**) has been prepared by G Cherry, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* Performance Report dated 12 December 2023.

# Assessment summary

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| Standard 8 Organisational governance | Not applicable as not all requirements assessed |

A detailed assessment is provided later in this report for each assessed Standard.

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

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

A decision of non-compliance made on 12 December 2023 followed an assessment contact on 25 October 2023 to 27 October 2023. At an assessment contact on 25 June 2024 the provider supplied a current/ongoing plan for continuous improvement (PCI), detailing improvement strategies including review of assessment processes in relation to environmental restrictive practice to ensure clear demonstration of individual needs in relation to restricting access; use of a perimeter restraint assessment tool; reassessment all consumers and update/redistribute the Restrictive Practices Guide.

Organisational changes demonstrate recognition a secure/locked door impacts individual consumer’s rights to access areas external to their living environment. The Restrictive Practices Guide (policy and procedure) has been updated and redistributed in 2024 to all services, detailing an environmental restrictive practice/intervention required at an individualised consumer assessment. As a method to ensure sustainable practice, regular monitoring actions enable a multi layered approach of support/management. In addition, clinical forums and internal audit programs ensure planned implementation at a service level to ensure changes as outlined in the Restrictive Practices Guide occurs. A new organisational staff training program relating to these changes has been implemented, Management monitor attendance noting 95% of staff completion.

Management advised consumers are subject to chemical, mechanical and environmental restrictive practices. Review of care planning documentation demonstrate informed consent and appropriate risk assessments in line with the Restrictive Practice Guide, plus regular review, and individualised Behaviour Support Plans exists. A review of consumers identified by the service as exhibiting unmet behaviours of concern, identified 59 consumers requiring a new restrictive practice reassessment. Representatives were provided with a consent document providing education regarding the definition of environmental restraint specific to the organisation’s cottage model environment. Fifty-one consent documents have been signed, and eight verbal consents received (awaiting documented signature). Sampled consumer documents detail appropriate processes occurred; the assessment tool identifies consumer impact and evidence risk assessment/consideration occurred for each consumer.

Effective organisational clinical governance of antimicrobial stewardship occurs via collection of monthly clinical infection data reviewed/actioned/analysed/trended and completion of a Board report, plus quarterly Medication Advisory Committee meetings. A medication advisory committee report includes comprehensive information on polypharmacy, chemical restraint medication, psychotropic medication use, opioids, anticoagulants, cytotoxic, medication incidents, infection types and prescribed antibiotics. An organisational antimicrobial stewardship policy has been effectively communicated to relevant parties. Senior clinical management and registered nurses demonstrate knowledge of antimicrobial stewardship describing actions taken to minimise antimicrobial use resulting in recent deprescribing for one consumer. Staff describe practices to ensure appropriate hygiene practices in preventing infection transfer. Training documentation demonstrates staff attendance regarding antimicrobial stewardship, and Management advise recent commencement of registered nurse education congruent with principles of best practice.

Effective organisational clinical governance ensures practice of open disclosure in complaint and incident management. Management team members demonstrate knowledge and staff demonstrate awareness of being open/transparent and provision of an apology. Review of five complaint documents demonstrate this has occurred. A review of four incident reports demonstrate representative notification, receipt of explanation, including actions to prevent recurrence. Staff receive training on a regular basis. Via review of policies/procedures, the assessment team note some anomalies between management and staff knowledge and policy guidance.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)