Performance

Report

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| Name: | Uniting Berrigan |
| Commission ID: | 0377 |
| Address: | 51-53 Davis Street, BERRIGAN, New South Wales, 2712 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 10 July 2024 |
| Performance report date: | 13 August 2024 |
| Service included in this assessment: | Provider: 1352 The Uniting Church in Australia Property Trust (NSW)  Service: 393 Uniting Berrigan |

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 Uniting Berrigan (**the service**) has been prepared by V Plummer, 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.
* the provider’s response to the assessment team’s report received 31 July 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** **Services and supports for daily living** | **Not applicable as not all requirements have been 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 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

A Site Audit conducted 14 to 16 May 2024 identified non-compliance in Requirements 3(3)(a) and 3(3)(b) and an Assessment Contact conducted on 10 July 2024, identified continued non-compliance in Requirements 3(3)(a) and 3(3)(b).

The Assessment Team report contained information in relation to deficiencies in wound management, pain management, and specialised nursing care needs.

In relation to Requirement 3(3)(a)

The Approved Provider in its written response to the Assessment Team report included documented evidence and they have implemented the following actions to ensure an appropriate level of clinical care and oversight is provided to consumers, including the following:

* Daily huddles are held in each household for both care and registered staff to discuss care and clinical concerns for consumers including risks. Appropriate measures are actioned and reviewed to address and mitigate any risks for consumers.
* A resident of the day process is in place to meet the holistic and changing needs and goals of consumers with each consumer’s clinical and care needs reviewed each month. Any changes are documented on the consumer’s care plan.
* Care plan reviews are completed every 3 months to reflect the changing needs of consumers and includes discussion with the consumer and/or representative.
* An annual review and case conference includes a comprehensive assessment review, identifying changes and updating consumers’ needs, goals, and preferences.
* Evidence based assessment tools are utilised, and the service documents clinical pathways for consumers with clinical care needs.

In addition to the process above the following actions have been taken to address non-compliance in relation to Requirements 3(3)(a). These actions include:

* Wound assessments have been completed and/or updated for 9 consumers with wounds and includes wounds photographed. Risk assessments have been completed where a pressure injury has been identified or if a consumer is at risk of developing a pressure injury or impaired skin integrity. Actions have been documented to reduce the risk for the consumer.
* Wound management strategies have been discussed with the consumer and/or representative.
* Consumers with pain have been reassessed and referrals completed to medical officers and allied health as required. The referrals include the request for medication reviews.
* Pain charts have been commenced for consumers who report they have pain, including post fall. Monitoring and documentation is completed following assessment.
* Consumers with specialised nursing care needs, including, behaviour support, end of life care, dementia and diabetes have been reviewed and referred to specialist staff for ongoing review as required.

Documentation, including progress notes, case conference notes, and referrals to medical officers and allied health professionals, was included in the Approved Provider's response. This documentation encompasses assessments, care planning, and care plan reviews, demonstrating that consumers with identified complex clinical care needs have been updated.

In relation to individual consumer issues contained in the Assessment Team report, the Approved Provider provided the following response:

* Consumers who have experienced a fall in the last 3 months have been reviewed and care plans updated. The incidents have been investigated with the outcome of the investigation communicated to consumers, representatives and staff.
* Wound monitoring and charting requirements have been communicated to clinical and care staff and education has been provided to staff, including contracted staff, on wound care documentation requirements. Registered staff have been advised to complete a wound assessment with each wound treatment, and to include photography of the wound.
* Pressure relieving equipment for consumers at risk of impaired skin integrity have been reviewed and in place as required.
* Behaviour support charting has been reviewed and updated to include individual strategies for consumers with changed behaviours and a memorandum issued to all staff on the documentation requirements for consumers with changed behaviours. Training has been completed on 25 July 2024, on serenity settling (therapeutic touch) for consumers with dementia.
* Medication management for consumers with chemical restrictive practice have been referred to the medical officer and their medication reviewed.
* Case conferences have been held for consumers with complex clinical care needs and the conference included the representatives who wished to be involved. A record of the meetings was shared with consumers and representatives.
* On 18 July 2024, post falls management was reviewed by the service and staff have been provided with information on the importance of documenting neurological observations, post fall for a consumer.
* A catheter task has been documented for consumers with indwelling catheters, in the electronic care documentation system for registered staff to follow, which provides a prompt for registered staff to alert them of the next catheter change date.
* Consumer with a diagnosis of diabetes and requiring subcutaneous insulin and regular blood glucose level testing, have has a review of their care and services resulting in updated care plans which reflect the medical officers’ directions with baseline parameters documented. The care plan also outlines the care staff responsibilities for consumers requiring insulin.
* Consumer requiring medication for pain management have been reviewed and registered staff informed via a memorandum of the requirement around pain assessments and monitoring and evaluation of pain post medication administration. The service has implemented weekly pain assessment and reviews for consumers who require pain medication. The service has met with registered staff one on one to discuss the signing omissions for as required medications.

In relation to Requirement 3(3)(b)

The Assessment Team report contained information relating to inconsistencies in completing clinical observations and information management relating to risks associated with consumer clinical care including falls, and medication administration.

The Approved Provider in its written response to the Assessment Team report included documented evidence and have implemented the following actions to deficiencies identified. These actions include:

* Consumers identified with high-risk concerns are entered onto the high-risk register, which is reviewed weekly by the service manager and senior clinical staff. Individual consumers are reassessed, and actions implemented to mitigate the identified risk.
* The organisational support team meet monthly with the service manager to monitor the clinical performance and effectiveness of outcomes and trends and ensure they are transferred to the continuous improvement plan.

In relation to individual consumer issues contained in the Assessment Team report, the Approved Provider provided the following response:

* Consumers who have experienced falls have been reviewed and referred to allied health for post fall review. On 18 July 2024, the service communicated to all registered staff (including contracted staff) outlining the falls management and prevention policy and flowchart which must be followed post fall. The service reports all falls have been investigated and reviewed, with neurological observations attended to in line with the policy.
* The service acknowledged neurological observations were not consistently completed and advised during the Assessment Contact this was an area where the service had implemented changes and was now completing observations in a timely manner. This was confirmed by the Assessment Team following a review of consumers documentation, who had experienced recent falls.
* For consumers with pain, the service has implemented pain charting and monitoring for consumers with identified pain and those requiring administration of as required pain medication, including signing of administration and monitoring for effectiveness.

Documentation, including incident reports, was provided by the Approved Provider which included details of the incidents, staff self-reflection and discussion about the incidents, which demonstrated the consumers experiences clinical incidents have been reviewed and actions applied to mitigate any further incidents.

The Approved Provider has stated in their response, the service manager has further discussed with registered staff the policy and procedure for post falls management, including neurological observations and medication management.

Minutes of a staff meeting, provided in the Approved Provider response, held on 18 July 2024, confirmed the service manager has discussed with clinical staff, the consumers who have recently experienced a fall, consumers who required as required pain medication evaluation and documentation, behaviour support charting, wound photography, neurological observations and the service’s weekly action log.

Consumers and representatives stated consumers receive personal and clinical care, which meets their needs, and they are satisfied with the suitability of staff, and the overall management of the service. Consumers and representatives said the staff are well-trained, kind and helpful and said they are partners in their care and services.

In coming to my decision, I place weight on the positive feedback from consumers in relation to how the service manages known risks to them and note no negative impact was reported for consumers.

I acknowledge the actions taken by the Approved Provider in response to the Assessment Team’s feedback regarding Requirement 3(3)(a) and Requirement 3(3)(b), along with the plan for continuous improvement plan submitted on 31 July, 2024. The Approved Provider has identified areas for improvement and initiated strategies to address them. I also acknowledge the Approved Provider's prompt response following feedback from the Assessment Team on-site, specifically in addressing consumer care needs and interventions discussed during the site visit. The provider's response and plan for continuous improvement demonstrate that the identified deficits have been addressed, along with future planned actions to improve performance under these requirements. Additionally, the service has communicated updates and provided direction to staff through meetings, as well as completing necessary training and education.

Therefore, it is my decision Requirement 3(3)(a) and 3(3)(b) are Compliant

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

This Requirement was found to be non-compliant at the Site Audit in May 2024. Consumers and representatives provided positive feedback on the safe and effective support and services they receive from the service which optimise consumer independence, quality of life and well-being.

Staff demonstrated knowledge of and described strategies on how they promote and support individual consumers’ emotional, spiritual and psychological needs. Care planning documentation included information on emotional, spiritual and psychological needs and preferences. Lifestyle staff described how they will schedule regular one on one chats with consumers as part of their emotional care. The service has in-service pastoral care associate who described emotional, spiritual, and psychological needs and preferences of individual consumers.

Actions have been taken to address non-compliance in Standard 4 in relation to Requirement 4(3)(d) identified following an Assessment Contact Site visit conducted on 10 July 2024. These actions have included:

* Implemented improvements to ensure care planning information includes consumers’ spiritual, emotional and lifestyle needs, and this information is communicated within the organisation or with others where responsibility for care is shared.
* Completed a review of all consumers leisure and lifestyle care plans to include the information consumers wish to share with others.
* The service has also employed the services of a qualified pastoral carer to visit
* consumers and discuss with them their ongoing needs and preferences. This
* position is a permanent and currently requires10 hours per week. The pastoral
* carer is supported by the organisations regional chaplain who also visits the service
* on a regular basis. The chaplain confirmed at interview, they are working with the lifestyle staff to meet with all the consumers and assist with the development of care plans
* for consumers which includes their spiritual, emotional and lifestyle needs. They are offering all consumers regular pastoral care support.
* The pastoral care staff have developed a relationship with the local clergy and in consultation with consumers, information about their preferences and needs has been included on the consumers care plans.
* The service has implemented a process to review the consumers every 6 months or more frequently if changes occur.

During this Assessment contact-site, the Assessment Team finds the organisation

has implemented improvements following the Site Audit and the Assessment Contact to address deficiencies identified.

In coming to my decision, I place weight on the positive feedback from consumers in relation to how the service manages their supports and services of daily living and I also acknowledge the Approved Providers actions to improve performance under this requirement.

Therefore, it is my decision Requirement 4(3)(d) is Compliant.

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)