Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Uniting Eabrai Weston ACT |
| Service address: | 12 Namatjira Drive WESTON ACT 2611 |
| Commission ID: | 2915 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 March 2023 |
| Performance report date: | 19 April 2023 |

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 Eabrai Weston ACT (**the service**) has been prepared by J Durston, 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 - 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.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | **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

|  |  |  |
| --- | --- | --- |
| 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 |

Findings

The service was found non-compliant in requirement 3(3)(a) following a Site Audit conducted 13 September 2022 to 15 September 2022. It was identified the service did not demonstrate best practice care, particularly for consumers who experienced restrictive practices and were subject to environmental restrictive practice. An assessment contact was conducted on 15 March 2023. The Assessment Team found the approved provider demonstrated consumers are receiving safe and effective personal and clinical care, that is best practice, tailored to their needs and optimises their health and wellbeing.

Consumer representatives interviewed provided positive feedback regarding the personal and clinical care their consumer receives, in areas including management of behavioural support and chemical and environmental restrictive practices, falls and pain management. Progress notes and consumer representative feedback indicated personal care is tailored to consumer needs.

The service’s restrictive practice policy reflects regulatory obligations and best practice. Sampled consumers’ care plans evidenced the service is meeting its legislative obligations in relation to the use of restrictive practice. Consumers subject to chemical restrictive practice have Behavioural Support Plans (BSPs) in place, evidence of consent and the use of alternative strategies prior to the administration of psychotropic medications. The service has BSPs and informed consent records for consumers subject to environmental restrictive practice due to cognitive impairment/behaviours.

For consumers sampled, the Assessment Team found unplanned weight loss was recognised and responded to appropriately. The organisation has a policy and procedures that reflect best practice guidelines in the management of skin integrity, pressure injuries, wound management and care documentation demonstrated aligned clinical practices.

The Assessment Team found the service had undertaken several continuous improvement actions in response to the Site Audit, including but not limited to, improved assessments and behaviour support plans (BSP) for consumers, increased clinical and management oversight of care and services, increased monitoring and auditing of pain assessments, pain charts and PRN (as required) analgesia use, and follow-up with the medical officer for excessive use to inform pain management. Staff education and monitoring of skin assessments and wound reviews have occurred. The restrictive practices policy was reviewed to clarify environmental restrictive practice processes, and information and consent forms for environmental restrictive practice were sent to all consumer representatives to gain consent. The resident of the day process was improved to include discussions by the registered nurse with representatives regarding restrictive practice issues related to their consumer and to answer any questions.

I therefore find Requirement 3(3)(a) is compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

The service was found non-compliant in requirement 8(3)(d) following a Site Audit conducted 13 September 2022 to 15 September 2022. It was identified consumer’s behaviours and incidents were not always captured within their incident management system. The service did not have adequate systems in place to capture incidents which were reportable under the serious incident response scheme (SIRS). An assessment contact was conducted on 15 March 2023. The Assessment Team found the approved provider demonstrated effective risk management systems to oversee and manage high impact high prevalence risk, and to manage and prevent incidents, including the use of an incident management system, including reporting SIRS incidents.

The Assessment Team found high impact and high prevalence risks are monitored on a risk spreadsheet and discussed at management meetings and monitored for changes. Management advised all priority one SIRS incidents are reported to the board outside of scheduled meetings. All others are raised and discussed in their regular meetings. Improvements to care identified in incident reports inform the service’s continuous improvement plan, and policies are updated. Staff interviewed were familiar with the service’s incident reporting system and confirmed they had log in access to report and escalate incidents.

The Assessment Team found the service had undertaken several continuous improvement actions in response to the Site Audit, including but not limited to, review of the environmental restrictive practices policy. Representative information and consent documentation was added for when their consumer requires care in a secure area and does not have pin pad access. The service conducted training on behaviour management, Serious Incident Response Scheme (SIRS) reporting and incident management.

I therefore find Requirement 8(3)(d) is compliant.

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