Performance

Report

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| Name of service: | Uniting Starrett Lodge Hamlyn Terrace |
| Service address: | 35-45 Louisiana Road HAMLYN TERRACE NSW 2259 |
| Commission ID: | 0541 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 August 2023 |
| Performance report date: | 19 September 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 Starrett Lodge Hamlyn Terrace (**the service**) has been prepared by B Bassett, 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

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| 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

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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

The service was found to be non-compliant in Requirement 3(3)(a) following a Site Audit conducted 22 February 2022 to 24 February 2022. The deficiencies related to wound care documentation and inconsistency in the implementation of policies and procedures related to wound management and skin integrity.

The service has taken actions to address previous non-compliance including;

* The engagement of external wound specialists for consumer referrals with the service’s Nurse Practitioner (NP) conducting weekly reviews and initiating referrals.
* The service updated the organisation's policy regarding wound management and skin integrity and conducted staff training on the updated procedures and guidelines.
* Staff undertook training related to wound management and skin integrity to improve their knowledge and skills and ensure more accurate recording of wounds and compliance with policies and procedures. The Assessment Team reviewed training logs and observed consistent documentation and photography of wound care for all sampled consumers.
* Increased clinical oversight of wound management practices via more frequent monitoring and supervision of the clinical team. The Assessment Team reviewed meeting minutes that included discussions of alternative wound care options with clinical staff and nutritional considerations.

The service regularly reviewed falls, weight loss, behaviours, medication, and pressure injuries. Various assessment tools and charts were noted to be available in the Electronic Computer Management System (ECMS) to inform staff delivery of care and services in supporting consumer needs.

Care planning specialist reports and clinical notes provided evidence of various strategies employed to address behaviour challenges for consumers subject to restrictive practices. These strategies included the use of pharmacological therapies for pain management and the management of behavioural and psychological symptoms associated with Alzheimer's and dementia.

The Assessment Team examined the service's weight monitoring charts for a named consumer. This indicated assessment by a dietician, followed by another review which outlined specific measures aimed at preventing weight loss, such as the inclusion of fortified drinks and continuous weight monitoring. An additional review had been planned to assess the effectiveness of these measures in preventing further weight loss.

The service’s Physiotherapist (PT) discussed precautionary measures implemented at the service to reduce the risk of falls for consumers. These measures included the use of a bed sensors, the provision of hip protectors and non-slip socks.

Care documentation identified wound charting for consumers was consistent with their wound treatment plan and the service’s wound care policies and procedures. Wounds were reviewed and documented with updates made to the wound management plan. Photos were on file to assess the wound's condition and track any changes over time.

Following consideration of the information above, I find that Requirement 3(3)(a) has returned to Compliance and is Compliant.

With respect to Requirement 3(3)(b), the service was found to be non-compliant following a Site Audit conducted 22 February 2022 to 24 February 2022, and the deficiencies related to the management of consumers’ diabetes and effective blood pressure monitoring.

The service has taken actions to address the previous non-compliance.

* The service introduced a diabetic management chart that records the type, frequency, and medication requirements of all consumers with diabetes. The monitoring of the diabetic management chart is the responsibility of the Deputy Service Manager (DSM) who reviews the chart on a daily basis to ensure consumers who require Blood Glucose Level (BGL) checks receive these, and that insulin is administered in a timely manner. In addition, the service’s ECMS alerts staff of actions required if log entries have not been recorded. Management advised this new process has improved effective monitoring of consumers with diabetes. The Assessment Team sighted the diabetic management chart that noted care delivery instructions.
* Management advised daily meetings with clinical staff have been implemented by the DSM in relation to the changing needs of consumers and to exchange information received from the NP and other Allied Health Practitioners. The DSM said care changes of consumers (including those with risks) are discussed daily to ensure identification and responses relating to consumer’s needs are attended to in a timely manner to reduce any safety concerns and/or risks. The Assessment Team reviewed the daily transcripts of discussions with staff recorded by the DSM relating to complex consumer care needs.
* While the service experiences issues with remoteness, it had coverage of Registered Nurses (RNs) 24 hours a day on duty at the service.
* The DSM said and evidence identified, regular charting of pain monitoring had improved the service’s response time to consumers. The DSM said consumers who experience pain are monitored every 4 hours over a 3-day period and staff record outcomes and the data is provided during handover and to the NP. The service has PRN medication charted for consumers who experience chronic pain to ensure they remain comfortable and pain free.
* Blood pressure monitoring included vital sign directives and set parameters have been established in the service’s ECMS.
* Management said the improvements they have initiated, and the expansion of the service’s leadership team has led to a higher level of early detection of consumers at risk and faster response times with managing their condition.

A review of sampled consumers care documentation identified risks were assessed and included information in relation to managing hydration and nutrition, risks of choking, managing pain, medications, diabetes management and evidence of blood pressure records. Care documentation included strategies and interventions for managing risk, to guide staff delivering care and services.

Management and staff were able to describe the high impact, high prevalence risks of consumers and the care and service delivery required to keep consumers safe.

Following consideration of the information above, I find that Requirement 3(3)(b) has returned to Compliance and is Compliant.

# Standard 8

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| 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 to be non-compliant in Requirement 8(3)(d) following the Site Audit conducted 22 February 2022 to 24 February 2022, and the deficiencies related to ineffective management of high impact and high prevalence risks associated with the care of some consumers. Specifically, risk associated with complex care, including diabetes management had not been monitored and medical directives and the organisations policies and procedures had not been consistently followed.

The service has taken actions to address previous non-compliance, including:

* The development of improved clinical management plans, including diabetes management, monitored by the DSM and providing clear directives for RNs and improved charting.
* Implementation of a clinical case management model delivering person centred care. RNs are accountable for clinical decision making with clinical practice overseen by the NP and the DSM.
* Education has been provided for staff including risk management and clinical best practice, along with increased clinical oversight to ensure compliance with the service’s policies and procedures. Evidence of attendance at training was provided to the Assessment Team.

The organisation demonstrated an effective governance framework incorporating a risk management plan which identified how risks associated with the care of consumers are managed and how consumers are supported to live their best lives.

Staff, including care staff and allied health, demonstrated a shared understanding of high impact and high prevalence risks to individual consumers, and described strategies to reduce risk whilst allowing consumers to live their best lives.

The organisation had policies and procedures relating to the identification and response to abuse and neglect of consumers. Documentation evidenced incidents were recorded, assessed, and reported to the Serious Incident Response Scheme (SIRS). The incidents requiring notification to SIRS were identified and reported within the required timeframes.

Following consideration of the above information I find that Requirement 8(3)(d) has returned to Compliance and 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)