Mercy Place Woree

Performance Report

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**Commission ID:** 5212

**Provider name:** Mercy Aged and Community Care Ltd

**Assessment Contact - Site date:** 6 January 2021 to 7 January 2021

**Date of Performance Report:** 18 February 2021

# Publication of report

This Performance Report **may 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

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| **Standard 3 Personal care and clinical care** | **Non-Compliant** |
| Requirement 3(3)(a) | Non-Compliant |
| Requirement 3(3)(g) | Non-Compliant |
| **Standard 7 Human resources** | **Non-Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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 Assessment Team’s Infection Control Monitoring checklist completed on 6 January 2021
* the provider’s response to the Assessment Contact - Site report received 2 February 2021
* intelligence hold by the Commission including referral information received.

# STANDARD 3 NON-COMPLIANT Personal 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 two of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team provided information that the service was not able to adequately demonstrate each consumer gets safe and effective clinical and personal care that is best practice and optimises their health and well-being relation to the management of medication, weight loss and restraint.

The Assessment Team identified ineffective clinical oversight in registered staff knowledge and practices in relation to monitoring consumer’s nutrition and hydration, pain, medication and falls management.

In response to the Assessment Team’s findings, the Approved Provider stated the organisation has a suite of Care Modules which outline how care is to be provided and ensures consistent knowledge and practice. However the Approved Provider’s response did not address the deficiencies identified by the Assessment Team in relation to the monitoring capabilities of registered staff knowledge and practice.

The Assessment Team identified one consumer who did not receive safe and effective care in regards to medication management: the consumer’s medication or their clinical needs were not reviewed by a medical officer for 23 days after entered the service; the consumer’s medication was continued to be administered by the service for 15 days after their hospital discharge medication chart with medication orders expired without consistent documentation to evidence the administration. In addition, a medication incident was not documented nor evidently followed up where a blood pressure medication was not administered to the consumer on time.

The Approved provider in its written response to the Assessment Team’s findings corrected the date when the consumer was seen by a medical officer, which means the consumer and their medication was reviewed by a medical officer on day 21 following the consumer entered the service and the consumer’s medication was administered without a signing chart with medication orders for 13 days. The Approved Provider acknowledged in its response that the delayed medical officer visit/review was ‘not ideal’ and the medication administration for the 13 days where a medication signing chart with medication orders had been expired was ‘less than optimal’. While I acknowledge there maybe medical officer shortage within the local area where the service is located and the Approved Provider ‘made a clinical decision’ to continue to provide the consumer with their medication under the circumstances, I was not persuaded every effect, such as refer the consumer to a local hospital, had been undertaken by the Approved Provider to engage a medical review. I am also not persuaded that the management of medication for this consumer was safe, effective or best practice.

The Assessment Team identified one consumer who did not receive personal and clinical care delivery which is best practice to optimise the consumer’s health and well-being in relation to the management of weight loss and medication. There was a 25 days delay in providing prescribed supplement to the consumer following the consumer lost 6.7 kilograms within a six-week period. Oral intake monitoring strategies for the consumer, including a ‘three day food and fluid chart’, were not followed by staff or evaluated by clinical staff. A regular medication that assists the consumer with sleep was withheld on 11 days between 18 November 2020 and 3 January 2021 without documented evidence to demonstrate the consumer’s changed medication need was communicated to or followed up by a medical officer in a timely manner to ensure the consumer’s safe and effective care delivery.

The Approved Provider in its written response to the Assessment Team’s findings acknowledged that they ‘did not take additional action (to source the prescribed supplement) as the usual supplier had advised that the product would be available however lengthy delays continued to be experienced by the supplier due to COVID-9 issues’. The Approved Provider advised that high energy high protein drinks which were provided to the consumer are not required to be entered in the consumer’s ‘nutritional supplement chart’. However the Approved Provider did not address the deficiencies identified by the team that a ‘three day food and fluid chart’ was not consistently recorded by staff or evaluated by management. Although I acknowledge that the consumer was provided with high energy high protein drinks during the delayed provision of prescribed supplement and the consumer has gained some weight in December 2020 and January 2021, I am not persuaded that the management of weight loss for this consumer was safe, effective or best practice. While I acknowledge that the medication which assists the consumer with sleep was withheld on multiple occasions due to the consumer was asleep, the Approved Provider’s response did not address the deficits identified by the Assessment Team in relation to timely communication with a medical officer in relation to the consumer’s changed medication needs.

The Assessment Team identified clinical care delivery that was not best practice in relation to restraint assessment, management and review. Three consumers were identified receiving physical restraint (environmental) without current restraint authorisations demonstrating discussion with the consumer and/or their representative and informed consent. Management was unable to advise how many consumers are receiving chemical restraint and review of restraint assessment/authorisation forms identified inconsistency in medical officers’ recommendation for chemical restraint or discussion with consumer and/or their representative in regard to alternative strategies or the risks associated with the use of psychotropic medication as restraint. The Assessment Team also identified one consumer who was administered regular psychotropic medication that was considered as chemical restraint without restraint assessment or authorisation.

In response to the Assessment Team’s findings, the Approved Provider did not provide information in relation to identified deficits in physical restraint (environmental) and has refuted the Assessment Team’s finding in relation to the management of chemical restraint. The Approved Provider’s response which included the organisation’s definition of receiving chemical restraint is ‘any PRN (as required) medication used for the purpose of modifying or controlling an aggressive or agitated behaviour’ and restraint assessment or authorisation are not required to be complete for regularly prescribed medications based on the organisation’s procedure further persuaded me that the organisation’s policies and procedures do not support its workforce in best practice in relation to chemical restraint in accordance with the restraint requirements in the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*. The identification, management and monitoring of chemical restraint usage is not best practice that optimise consumers’ health and wellbeing.

I acknowledge the actions taken by the Approved Provider in response to some deficiencies identified by the Assessment Team such as staff are reminded to create an incident report for medications that are not administered at prescribed time and record information in appropriate charts rather than in progress notes, however these actions do not fully address the deficiencies identified by the Assessment Team and have not been fully implemented or tested for their effectiveness.

I have considered the Assessment Team’s report and the Approved Provider’s response and I find that at the time of the Assessment Contact the Approved Provider did not demonstrate that consumers have received safe and effective clinical and personal care that is best practice, tailored consumers’ needs or optimising health and wellbeing.

I find this Requirement is non-compliant.

### Requirement 3(3)(g) Non-compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The Assessment Team provided information that the service is unable to demonstrate they have an established coordinated approach to the management of a possible outbreak of COVID-19. The service could not demonstrate it considers environmental factors that may contribute to contamination and cause infection control risks for consumers.

The Assessment Team completed an Infection Control Monitoring checklist during the performance assessment and identified a range of deficiencies in relation to the service’s preparedness for a COVID-19 outbreak, including in relation to the service’s outbreak management plan, personal protective equipment usage, environment and equipment cleaning and signage related to infection control measures.

The Assessment Team also identified deficiencies in environmental factors that may contribute to contamination and cause infection control risks for consumers. For example: flies were observed to be presented and landed on consumers lunch meals in consumer rooms; trolleys with consumer food and beverages were observed uncovered with flies to be presented; the surface area where tea and coffee making facilities are located within a palliative care room was observed grimy to touch; poor condition in some shared bathrooms including grimy appearance with tiled areas and mouldy odour observed.

The Approved Provider in its written response has refuted the Assessment Team’s finding in relation to the deficiencies identified in the Infection Control Monitoring checklist. While an ‘outbreak response upon notification of positive case’ documented was provided as part of the response, the Approved Provider did not address the deficits identified in relation to the service’s outbreak management plan, personal protective equipment usage, environment and equipment cleaning and signage related to infection control measures.

In regards to deficiencies in environmental factors that were identified by the Assessment Team, the Approved Provider’s response stated other methods the service uses to minimise flies including a ‘bug zapper’ outside the kitchen and a two-door system between outside of the building and kitchen corridor, however these methods do not address the deficiencies observed where flies to be presented and landing on consumers’ food in their rooms. The Approved Provider acknowledged that some shared bathrooms require maintenance work including painting, replacement of rusted fittings, new floor diminishing strips and re-gluing over vinyl.

I acknowledge the actions taken by the Approved Provider in response to some deficiencies identified by the Assessment Team such as:

* arrangements have been made to fit the trolleys with covers to prevent access by flies following the performance assessment
* the tea/coffee and sink area within the palliative care room was cleaned during the performance assessment and cleaning supplies for the area are now readily accessible by consumers/representatives
* condition in shared bathroom was observed by a cooperate manager and deficiencies ‘are to be rectified through internal maintenance program in the next few weeks’.

However, these actions do not fully address the deficiencies identified by the Assessment Team and have not been fully implemented or tested for their effectiveness.

I have considered the Assessment Team’s report and the Approved Provider’s response and I find that at the time of the Assessment Contact the Approved Provider did not demonstrate that appropriate steps had been considered and implemented for the minimisation of infection related risks.

I find this Requirement is non-compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

Whist the organisation has a workforce that is general sufficient, skilled and qualified, the workforce is not always trained, equipped and supported to deliver the outcomes required by the Quality standards.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team provided information that the service did not effectively monitor staff practice in safe and quality care delivery in relation to consumer’s nutrition and hydration needs and identified deficiencies in one consumer who experienced delayed assistance from staff.

The Approved Provider’s response refuted the deficiencies identified by the Assessment Team in delayed staff assistance for one consumer and provided clarifying information including care planning strategies to for the consumer.

The monitoring of capabilities of staff practice in safe and quality care delivery in relation to one consumer’s nutrition and hydration needs are considered in non-compliance decision Requirement 3(3)(a).

I have considered the Assessment Team’s report and the Approved Provider’s written response and whilst the Assessment team recommended this requirement was not met, on balance of the information presented to me, I find the service has systems and processes to ensure the number and mix of the planned workforce deployed enables the delivery and management of safe and quality care and services.

I find this Requirement is compliant.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team identified deficiencies in training and provision of support to the workforce, especially for clinical staff, in relation to minimising the use of restraints. The Approved Provider provided evidence that clinical staff had received training in ‘restraint free policy’ and ‘restrictive practice procedure’ in February 2020. Whist I acknowledge that the training was provided, the effectiveness of the training, monitoring of staff understanding and practice in relation to identification and management of restraint was not evidenced.

The Assessment Team found ineffective monitoring processes to ensure training and provision of support to workforce are delivered as planned which include competencies in hand washing and manual handling. The Approved Provider did not address these deficits identified by the Assessment Team in it’s written response.

In relation to not all registered staff have received training in how to use the organisation’s electronic care planning system, the Approved Provider acknowledged ‘a gap in face-to -face education’ of new clinical and care staff and stated an online approach to replace the face-to-face training has been recently developed.

I have considered the Assessment Team’s report and the Approved Provider’s response and I find that at the time of the Assessment Contact the Approved Provider did not demonstrate that its workforce is trained, equipped and supported to deliver the outcomes required by the Quality standards.

I find this Requirement is non-compliant.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Although the organisation’s governing body is generally accountable for the delivery of safe and quality care and services, the organisation does not have effective organisation wide governance systems relating to regulatory compliance.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Non-compliant

*Effective* *organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

In relation to financial governance, the Approved Provider’s response indicated that actions have been put in place to address the deficiencies identified by the Assessment Team including new chairs ordered and planned refurbishment of the shared bathrooms.

The Assessment Team identified the organisation does not ensure effective governance systems and processes comply with legislative changes in relation to minimising the use of restraints. Whist the Approved Provider provided information in its response including the organisation’s definition of receiving chemical restraint and procedures in chemical restraint related risk assessment, care planning and authorisation, the evidence provided is not in accordance with the restraint requirements in the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019.

I have considered the Assessment Team’s report and the Approved Provider’s response and I find that at the time of the Assessment Contact the Approved Provider did not demonstrate effective organisation wide governance systems in relation to regulatory compliance. I find this Requirement is non-compliant.

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

The Assessment Team provided information that the organisation is unable to demonstrate how it ensures the service delivers care and services in line with organisational policies and procedures in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure.

The Approved Provider’s response refuted the deficiencies identified by the Assessment Team and provided clarification and evidence on how antimicrobial stewardship and open disclosure is applied organisation wide.

Staff knowledge, practice and the monitoring capabilities in safe and quality care delivery in relation to minimising the use of restraint has been considered in non-compliance decisions in Requirement 3(3)(a), Requirement 7(3)(d) and Requirement 8(3)(c).

Deficits identified in relation to ineffective training and support delivered to staff in antimicrobial stewardship, minimising the use of restraint and open disclosure has been considered in non-compliance decision in Requirement 7(3)(d).

I have considered the Assessment Team’s report and the Approved Provider’s written response and whilst the Assessment team recommended this requirement was not met, on balance of the information presented to me, I find at the time of the Assessment Contact there is generally a clinical governance framework.

I find this Requirement is compliant.

# 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.

* Requirement 3(3)(a) – The Approved Provider ensures that each consumer gets safe and effective care that is best practice, is tailored to their needs, and optimises their health and well-being, particularly for those consumers with complex or specialised care needs.
* Requirement 3(3)(g) – The Approved Provider ensures that it minimises infection-related risks through implementing standard and transmission-based precautions to prevent and control infection, particularly in relation to COVID-19 and environmental factors that may contribute to contamination and cause infection control risks for consumers.
* Requirement 7(3)(d) – The Approved Provider ensures its workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards, particularly for clinical staff with training needs to ensure safe and effective clinical and personal care delivery.
* Requirement 8(3)(c) – The Approved Provider ensures organisation wide governance systems is effective, particularly for regulatory compliance in relation to minimising the use of restraint.
* The Approved Provider establishes monitoring process to ensure ongoing compliance with the Aged Care Quality Standards.