MercyCare Maddington

Performance Report

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**Commission ID:** 7270

**Provider name:** Mercy Human Services Limited

**Assessment Contact - Site date:** 30 June 2020

**Date of Performance Report:** 18 August 2020

# 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 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | 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 provider’s response to the Assessment Contact - Site report received 10 July 2020.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 26 November 2019 to 27 November 2019.

The Assessment Team recommended Requirement (3)(a) in Standard 1 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 1 and find the service is Compliant with Requirement (3)(a).

At a Site Audit conducted 26 November 2019 to 27 November 2019, in relation to Standard 1 Requirement (3)(a), the Decision Maker found the service did not demonstrate each consumer is treated with dignity and respect.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

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The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Providing staff with training to assist them to ensure consumers are treated with dignity and respect in a kind and caring manner.
* A review of documentation to ensure terminology reflects person-centred language.
* Reviewing procedures for conducting care reviews and other assessment processes in public areas.

In relation to Standard 1 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives interviewed stated staff treat them with dignity and respect. Representatives said staff encouraged them to share information regarding consumers to assist them to get to know the consumer as an individual.
* Consumers and representatives provided examples of the ways in which staff value consumer’s identify, culture and diversity. Representatives said that with recent changes in staff they have been provided with an opportunity to share with staff the consumer’s specific preferences and these have been implemented.
* Consumers and representatives said that having the ‘locked doors’ open during the day has provided an opportunity for consumers to be able to move freely throughout the service, and as a result there has been less intrusion into other consumer’s rooms.
* Representatives said that during the COVID-19 pandemic, management and staff continued to provide information and seek feedback to ensure consumers remained connected to things which were important to them, such as family, religious connections and their culture.
* Staff interviewed consistently spoke about consumers in a way which indicated respect and that they were familiar with consumers’ background and preferences and how this influenced the day-to-day delivery of care.
* The Assessment Team observed staff interacting with consumers in a respectful manner. This included encouraging consumers to participate in activities, engaging consumers in everyday tasks and seeking their permission before attending to personal care. Staff were observed assisting consumers with their meals and encouraging independence where possible, engaging consumers in conversation and providing choice as meals were served.
* Management said consumers and representatives are regularly asked about the extent to which consumers feel valued and respected, through formal and informal feedback mechanisms. These include audits, surveys, compliments and complaints feedback, meetings, and care conferences.
* Management said the decision to open the ‘locked’ doors between the two secure wings during the day has assisted consumers to move freely between the two wings and the courtyard. Management said there has been a decrease in behaviours since the opening of the doors. Incident data confirmed there has been a reduction in the number of consumer incidents.
* A review of care plan documentation by the Assessment Team indicated consumers’ specific preferences are documented to guide staff.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(a) of Standard 1.

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as one of the five specific Requirements have been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 26 November 2019 to 27 November 2019.

The Assessment Team recommended Requirement (3)(a) in Standard 2 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 2 and find the service is Compliant with Requirement (3)(a).

At a Site Audit conducted 26 November 2019 to 27 November 2019, in relation to Standard 2 Requirement (3)(a), the Decision Maker found the organisation did not demonstrate that assessment and planning identified risks to consumers’ health and well-being or informed the delivery of safe and effective care and services in a timely manner.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Reviewing assessments of consumers to ensure compliance with the service’s policies.
* Reviewing monitoring of assessment processes to ensure assessments are undertaken in accordance with the service’s policies.

In relation to Standard 2 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said staff assist them with walking and transfers, including exercises with the Physiotherapist.
* Representatives said that while they have not had an opportunity to fully discuss care plan information because of COVID-19 restrictions, management are approachable, and they are confident consumers’ preferred care choices are respected.
* The service undertakes assessments in accordance with the organisation’s processes when consumers enter the service. This includes assessments over the initial period before the care plan is developed. Any identified change to a consumer’s health status triggers a re-assessment which is completed by a Registered Nurse.
* Allied health assessments are completed by the Occupational Therapist and the Physiotherapist to identify consumers’ needs and preferences. A care plan is subsequently developed.
* Therapy staff said they are responsible for implementing the programs as outlined in the consumer’s care plan. Any change in consumer needs and preferences are reported and discussed at a weekly team meeting.
* A multi-disciplinary team meeting is held weekly with clinical and allied health staff in attendance. Clinical incidents, changes in consumers’ conditions, behaviours, or preferences are discussed and information recorded in progress notes. This information is shared with all registered and care staff and the information is included in the consumer’s care plan.
* The Assessment Team viewed documentation which confirmed the service’s electronic care planning system creates worklogs for staff to complete as part of their shift, including reposition charts, behaviour charts or continence charts. Care staff confirmed they record information on the appropriate charts and this information is used by nursing staff to develop or review consumer’s care plans.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(a) of Standard 2.

# STANDARD 3 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 Compliant as two of the seven specific Requirements have been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(b) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 26 November 2019 to 27 November 2019.

The Assessment Team recommended Requirements (3)(a) and (3)(b) in Standard 3 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 and find the service is Compliant with Requirements (3)(a) and (3)(b).

At a Site Audit conducted 26 November 2019 to 27 November 2019, in relation to Standard 3 Requirements (3)(a) and (3)(b), the Decision Maker found the service did not demonstrate:

* Consistent and effective management of consumers who display aggression, or inappropriate sexual advances, including uninvited physical contact.
* Safe and effective falls management for consumers at high risk of falls.
* Effective management of incidences of high impact or high prevalence risk associated with the care of each consumer.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Implementing a monitoring process for staff to effectively monitor that consumer’s needs and preferences are met, including the monitoring of aggressive and sexually inappropriate behaviours, to minimise the impact to other consumers.
* Reviewing monitoring processes to identify staff failure to follow the organisation’s processes.

In relation to Standard 3 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives confirmed they are provided with timely personal and clinical care which is safe and is provided in the manner they have requested.
* Consumers and representatives said staff know what they need and can assist them when required.
* Representatives said staff have been supportive and provide ongoing information. Representatives said there has been an improvement in the care provided to consumers and while staff are busy, they take the time to ensure consumers get the care they prefer.
* Management confirmed nursing and allied health staff evaluate the effectiveness of each consumer’s clinical care needs and any changes identified are discussed at the weekly multi-disciplinary team meetings.
* The service has trialled strategies to address physical and verbal aggression between consumers, including referral to external organisations.
* Staff said there are documented policies and procedures to follow and they are informed of changes to procedures and practices via the intranet, meetings, memoranda and shift handovers.
* Staff interviewed described the clinical and personal care they provide to consumers.
* The Assessment Team viewed assessments, care plans and progress notes which reflect that care is individualised, is safe and effective and tailored to the specific needs and preferences of each consumer.
* Staff are provided with orientation and undertake additional training to their roles and responsibilities through the organisation’s mandatory training program and optional training program.
* The organisation has written policies and processes which staff can access from the intranet. Updated policies and processes are provided to staff through meeting minutes.
* The organisation trends, analyses and responds to high impact or high prevalence risks by reporting each incident and completing an analysis as to the cause. Clinical indicator data is discussed at the weekly multi-disciplinary team meetings and any identified trends are referred are referred to the organisation’s monthly clinical management team to assist with the identification of continuous improvement.
* The Assessment Team noted that staff document challenging behaviour incidents in consumers’ behaviour charts. The information is reviewed by the Registered Nurse and if required, a behaviour assessment is completed, and the strategies included in the care plan documentation. The Assessment Team viewed consumer progress notes which showed routine evaluation of care provision, including the monitoring of consumers’ weights, following a fall or when specific clinical needs are identified.
* In relation to restraint, the organisation has a restrictive practices policy and processes on restraint free and restraint minimisation. The Assessment Team confirmed staff track consumers who are using prescribed psychotropic medications, including trialling non-pharmacological strategies, review by a Medical Practitioner, and with consent of the consumer and/or representative. Management said the service is working with Medical Practitioners to reduce the use of psychotropic medication.
* In relation to skin integrity, the organisation has policies and processes to ensure effective skin integrity. The Assessment Team noted from documentation that skin issues are reported and recorded, and each consumer has an assessment, with documented goals and interventions in their care plan. In relation to wound management, the service records each wound and implements a wound management plan. Photographs are taken on the progress of the wound and evaluation completed by clinical staff.
* In relation to pain management, the Assessment Team noted a consumer’s pain is assessed at least three monthly or when there are changes in a consumer’s health. Consumers have specific care plans for pain, including assessment and the documentation of non-pharmacological strategies. Staff said they monitor consumers for pain.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(a) of Standard 3.

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

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* A review of the service’s practices for the management of high impact or high prevalence risks.

In relation to Standard 3 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives said consumers have access to appropriate clinical and other specialists to manage their complex health needs, including when there has been an incident affecting them.
* Consumers said that when they may be impacted by another consumer’s challenging behaviours, the service has implemented strategies to minimise the impact.
* Registered staff described strategies in place for high impact or high prevalence risks for consumers, including consumers who experience frequent falls, display behaviours, and weight loss. Strategies include both pharmacological and non-pharmacological interventions.
* The Assessment Team noted risks for consumers, such as falls, weight loss, behaviours and swallowing, are recorded in assessments, progress notes and care plans. Referrals are made to external organisations as required.
* Incidents, such as challenging behaviours, falls and skin tears, are documented, actioned and monitored appropriately. Assessments are conducted by Registered Nurses and Allied Health staff and recommendations documented in the care plan, including recommendations from external service providers. Staff were observed by the Assessment Team using the strategies as outlined in the care plans.
* All high impact and high prevalence clinical and personal risks for consumers are recorded in care plans, assessment and progress notes. Each incident is recorded and analysed, and strategies implemented to avoid a re-occurrence. Re-assessment of the consumer’s needs are undertaken as issues are identified.
* Wounds, pain management and weight loss are followed up by Registered Nurses and specialist services, including Speech Pathologists, Dietitians and wound specialists, in liaison with Medical Practitioners. Treatment is provided according to the consumer’s specific clinical needs. Care plans include regular monitoring of high impact clinical risks.
* The service maintains a high-risk resident register which is updated monthly in consultation with the multi-disciplinary team.
* The service trends, analyses and responds to high impact or high prevalence risks by reporting each incident. Clinical indicator data is discussed at the multi-disciplinary team meetings to assist with the identification of improvement opportunities.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(b) of Standard 3.

# STANDARD 8 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

The Quality Standard is assessed as Compliant as two of the five specific Requirements have been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 26 November 2019 to 27 November 2019.

The Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 8 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service is Compliant with Requirements (3)(c) and (3)(d).

At a Site Audit conducted 26 November 2019 to 27 November 2019, in relation to Standard 3 Requirements (3)(a) and (3)(b), the Decision Maker found that:

* The approved provider did not follow Aged Care legislative requirements with regard to compulsory reporting of elder abuse.
* The service did not undertake care plan reviews for behavioural management strategies within 24 hours following incidents of physical aggression or sexually inappropriate behaviour of consumers.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* A review of the organisation’s approach to compulsory reporting and actions to be taken following a discretionary decision to not report in accordance with legislative requirements.
* Providing additional training to staff on responsibilities for reporting incidents.

In relation to Standard 8 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives said the organisation is well run and they can partner in improving the delivery of care and services.
* Representatives said communication about the COVID-19 pandemic and access restrictions was useful and welcome, and they understand the reasons for restricting access to the service.
* The organisation has appropriate governance systems addressing information management, financial governance, workforce governance, regulatory compliance and feedback and complaints as follows:

Information Management:

* The organisation has an electronic care planning system which is password protected. Staff have access to computerised consumer care documentation and access to portable electronic tablets for easy access to consumer documentation.
* Staff said they have ready access to the information they need, and they are able to access up to date information about consumers or recent staff communications.

Continuous Improvement:

* The organisation maintains a Plan for Continuous Improvement which addresses a range of actions, including organisational and site-specific initiatives, quality indicator data, audit results, feedback and suggestions, and industry updates.

Financial Governance:

* Management described how the Service Manager has a budget which is approved through the Finance and Audit Committee of the Board.
* The organisation maintains a capital expenditure budget, a portion of which is for major maintenance and works.

Workforce Governance:

* Management said duty statements are currently under review. The organisation is involving staff in the redevelopment of the duty statements.

Regulatory Compliance:

* The service has provided additional mandatory reporting training to staff, including toolbox and face-to-face training.
* As the Service Manager is on call 24 hours a day, seven days a week, during training staff were advised to contact the Service Manager immediately after an incident occurs. Staff have been advised to call even if they are unsure whether the incident is reportable.
* The service has improved their shift handover report, which is discussed at every shift handover and reviewed by the Service Manager. The report covers medication, wounds and incidents.
* The service has processes for ensuring all incidents are investigated and appropriate reviews and referrals are made within the legislative timeframe. All incidents are considered by the Clinical Governance Committee, to identify any organisational corrective action which may be required.
* Management said verbal reporting has improved and staff are no longer just recording details in a progress note in the system. Staff are to ensure the appropriate staff member is informed as soon as possible. Management review progress notes regularly to identify matters which may require actioning.
* Management review incidents and handover notes and senior managers complete an overview of incidents.
* The organisation has reinforced the escalation matrix, which is on display in the nurses’ station.
* The service has commenced twice daily ‘catch up’ sessions to provide any additional training, operational updates, mandatory reporting items and to discuss anything which may have occurred that day. The sessions are responsive to what is occurring within the service.

Feedback and Complaints:

* The organisation encourages feedback from consumers, representatives and staff and analyses and addresses the issues from the feedback provided.
* The organisation conducts regular surveys and audits to identify issues. The organisation uses an audit tool which involves conducting several separate surveys throughout the year. The results are analysed and evaluated by the organisation.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(c) of Standard 8.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Providing training to management and staff regarding compulsory reporting requirements and the identification of elder abuse.
* The service has updated the ‘non-reportable’ log to include the reason for not reporting the incident.

In relation to Standard 8 Requirement (3)(d), a sample of consumer files viewed, and information provided to the Assessment Team by staff through interviews demonstrated:

* The organisation demonstrated it has effective risk management systems and practices to manage high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can.
* In relation to managing high impact or high prevalence risks associated with the care of consumers, the service demonstrated that it consistently assesses, plans and manages consumers with aggressive and sexually inappropriate behaviours, and consumers with a high risk of falls.
* In relation to identifying and responding to abuse and neglect of consumers, the service demonstrated it identifies and responds in a timely manner. The service maintains a register of reportable incidents and non-reportable incidents.
  + The Assessment Team viewed the reportable incidents register and noted that incidents reported in the last six months have been appropriately reported to the police and the Department of Health, within the legislative timeframes. The documentation also confirmed behaviour charting and re-assessments have been updated within the appropriate timeframes, and if required, referrals made to external organisations.
  + The Assessment Team viewed the non-reportable incident register and noted after each incident behaviour assessments were updated and reviewed by clinical staff and the Medical Practitioner. Families were notified of the interventions implemented. The reasons for not reporting were also identified on the register.
  + The service has provided additional training for staff to ensure they know their responsibilities for reporting incidents and the requirement to review behaviour management strategies within 24 hours of the incident occurring.
* In relation to supporting consumers to live the best life they can, the service demonstrated it has changed the service environment by unlocking the doors to each of the wings so that consumers can use the environment as they wish.

For the reasons detailed above, I find the approved provider, in relation to MercyCare Maddington, does comply with Requirement (3)(d) of Standard 8.

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