Performance

Report

**1800 951 822**

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| Name of service: | Embracia Moonee Valley |
| Service address: | 76-86 North Road AVONDALE HEIGHTS VIC 3034 |
| Commission ID: | 4560 |
| Approved provider: | Embracia Victoria Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 January 2023 to 5 January 2023 |
| Performance report date: | 7 February 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 Embracia Moonee Valley (**the service**) has been prepared by L Glass delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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
* the provider’s response to the assessment team’s report received.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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

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.

* Ensure that the preferences and needs for consumers personal care needs are implemented as per the consumer’s negotiated care plan and personal care provision is monitored and delivered.
* Where alternative personal care provision is provided it is tailored to the individual’s personal care needs, optimises the individual’s health and well-being, is regularly monitored and reviewed and the rationale for the alternative provision is communicated to the consumer/ and or their representative and documented appropriately.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

In relation to requirement 3(3)a, the service was found non-compliant in this requirement following an Assessment Contact from 5 April 2022 to 6 April 2022. The Assessment Team noted not all consumers were receiving appropriate and safe personal or clinical care, tailored to their needs and according to best practice. The Assessment Team found that personal care was not being delivered in accordance with the consumers preferences or needs and that the documentation in relation to restrictive practices was unclear, and discussion regarding consent was not always evidenced.

The service’s plan of continuous improvement dated 29 July 2022 included actions to improve the delivery of personal care that consumers received in line with their preferences; understand what constitutes a restraint, and ensure all those consumers have assessments, informed consent and can display consistent reviews and monitoring and provide appropriate pressure injury prevention and effectively manage wounds.

During the Assessment Contact conducted from 4 January 2023 to 5 January 2023 the actions outlined in the plan for continuous improvement were not always effectively implemented.

The Assessment Team found 3 consumers and 8 representatives reported a lack of assistance relating to personal hygiene and personal care not being delivered according to the consumer’s needs and preferences. In particular, concerns were raised about showering preferences not being provided and sponge baths and quick wipes occurring instead. For two consumers, their representatives reported consumer personal hygiene needs were not being met. They were not satisfied with the regularity of personal care delivery resulting in odours and in one case issues with skin integrity. Another consumer has a chronic wound and there was ambiguity about the capacity to shower and the alternative options available. Consumers and representatives also reported staff were rushed or lacked the time to action personal care.

In response to the Assessment Team report the Approved Provider supplied further information and clarification and refutes the findings of the Assessment Team in particular in relation to a lack of provision of inadequate personal care for consumers. The Approved Provider contends the Assessment Team has disregarded discussions and explanations provided at the Assessment Contact and that variations to consumers’ showering regime is due to resident choice reflected in consumer’s care plans and inferences that this is due to staff shortages and not managing behaviours is incorrect.

The Assessment Team found the service has implemented actions to document and review the consumers subject to restrictive practice, but it requires improvement in staff understanding and application of restrictive practices. The Assessment Team found that rather than individualised consent requests and completed forms being in place tailored to a consumer subject to restrictive practice. For example, for chemical or mechanical restraint, there was a generic consent form in place for all consumers unless the consumer or representative declined consent. The documentation provided by the service had several discrepancies in relation to what constituted use of chemical restraint indicating further understanding is needed for staff to understand, apply and document restrictive practice in line with legislative requirements.

In relation to the Assessment Teams concerns about further improvements needed to understand restrictive practices the Approved Provider refutes the Assessment Teams’ characterisation of generic forms used for consent and the Assessment Team’s findings that its use and understanding of restrictive practice is not in line with legislative requirements. The Approved Provider clarified its use of forms interpreted as generic by the Assessment Team and demonstrated that it has a sound understanding of restrictive practices, in particular chemical and mechanical restraint.

The Assessment Team found while improvements have been made in relation to recognising, managing, and correctly staging pressure injuries and active wounds for most consumers reviewed, a review of the wound chart for one consumer demonstrated the pressure injury was not being dressed at the documented frequency. However, there was no impact on the consumer and the wound was healing. Pressure area care was being managed for the consumer reviewed.

In making my decision I have considered the Assessment Team Report and the response for the Approved Provider. I accept the Approved Provider’s evidence it has addressed the previous non-compliance in relation to applying legislative requirements in the use of restrictive practices. I accept the explanation from the Approved Provider that the discrepancies in documenting chemical restraint for two consumers was an administrative error and immediately rectified and had no impact on the two identified consumers who also had documented diagnoses.

While I acknowledge the improvements made by the Approved Provider in response the non-compliance found in April 2022, I am persuaded by the information in the Assessment Team report about consumers and representatives expressing dissatisfaction with personal care. I have given weight to the inconsistencies and deficits reported by consumers and representatives about the personal care received and the reported impact on consumers wellbeing. The response from the Approved Provider does not in my view address all of the concerns raised. The response does not provide supporting evidence to demonstrate the claims made about for example, consumer preferences in care plans and there is conflicting information provided by the consumers and their representatives about the preferences, needs and provision of personal care delivery. Consumers are not satisfied with the personal care provided. I therefore find requirement 3(3)a Non-compliant.

In relation to requirement 3(3)b the service was found to have non-compliance in this requirement following an Assessment Contact conducted from 5 April 2022 to 6 April 2022. The service was found to have deficits in the effective management of consumer’s clinical condition in relation to effectively managing high impact and high prevalence risks for the consumers’ skin integrity.

The service provided a plan of continuous improvement dated 29 July 2022, to address the identified gaps focusing on improvements in managing high impact high prevalence risks. To improve staff recognising and responding to consumers who have a decline in their clinical condition and require reassessment of care needs, education sessions were delivered to ensure staff understood the process to report, document and escalate identified changes in the consumers’ condition. The service undertook an audit of all consumers’ care plans to ensure currency, and care plans reflected accurate care interventions to meet the needs of the consumer.

The service reviewed and updated the service’s care plan review schedule to ensure every consumer is reviewed regularly through the monthly resident of the day (ROD) review. During the Assessment Contact on 4 January 2023 to 5 January 2023, the service demonstrated improvement in this requirement in identification and effective pressure injury management. As part of implementing the plan of continuous improvement an audit of wound management and consumer weight charting was undertaken. This was to ensure procedures were being followed correctly and were timely, including for weight management. The audit also involved a review of referrals to ensure where needed referral to a general practitioner or dietician was actioned.

The service demonstrated evaluation and trending of clinical incidents and the process of the review and closure of each incident following reassessment and updating care interventions. The service provided a range of policies and procedures on clinical practice including skin and wound management and falls management and prevention.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |

Findings

The service was found non-compliant with this requirement following an Assessment Contact conducted from 5 to 6 April 2022. The service did not demonstrate the emotional and psychological support provided to consumers who experienced distress following incidents of verbal or physical aggression is tailored to meet the individual consumer’s emotional needs. The Assessment Team reviewed the service’s updated plan for continuous improvement, consumer files, and other supporting documentation, and conducted interviews and observations confirming action plans have been generally effective.

The service has established an ongoing lifestyle ‘room visit program’ to ensure consumers not attending group activities receive emotional and social support. Reviews of incidents involving a consumer include identification of whether the incident has caused distress that requires the provision of emotional or social support. The referral process has been improved and includes the involvement of external counsellors, a psychologist and community or spiritual leaders.

Staff ensure consumers are supported emotionally and spiritually by providing reassurance when incidents happen and making sure the consumers are kept connected with their representative or family member.

The Assessment Team reviewed 8 consumer files and noted daily progress notes for all consumers reviewed reflect one-to-one support and individualised activities are provided. While there was some mixed feedback received from representatives about emotional support provided to consumers the Assessment Team found the service is committed to embedding improvements initiated since the previous Assessment Contact. Overall consumers and representatives were satisfied with the emotional, spiritual and psychological support received. The Assessment Team observed lifestyle and care staff providing one-to-one support to consumers requiring behaviour management and encouraging consumers to attend a church service.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The service was found non-compliant with this requirement during an Assessment Contact conducted from 5 to 6 April 2022. The gaps in the care provided to the consumer raised concerns about the sufficiency of the service’s staff skills and knowledge around wound assessment, classification, management and monitoring, and the implementation of preventative strategies.

The service’s plan of continuous improvement dated 29 July 2022 included actions to address staff knowledge in relation to wound management. The Assessment Team found the service has implemented planned actions to ensure staff are effectively performing the roles for which they have been recruited. The service implemented a new leadership team, appointing a new facility manager and clinical care coordinator along with other management roles. All new management roles were filled by registered nurses to facilitate comprehensive oversight of clinical care. The new general manager guides the service’s leadership team in performing their roles.

# 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 non-compliant with this requirement during an Assessment Contact from 5 to 6 April 2022. The identified deficits include the service was unable to demonstrate how risks associated with pressure injuries and the use of restrictive practice are identified and managed effectively to ensure consistent and safe staff practice. The service also did not demonstrate risks management is effective in relation to the investigation and follow-up of consumers who are subject to abuse by other consumers.

The service demonstrated improvements in this requirement through the implementation of actions outlined in its plan for continuous improvement dated 29 July 2022. Data continues to be reviewed and collated and the service identifies trends in high impact and high prevalence risks. Scheduled clinical auditing is completed and outcomes are analysed for gaps that need improvement which is followed up with staff training and procedure review. The service implemented an audit on the use of restrictive practices including mechanical and chemical restraint. All identified consumers subject to restrictive practice have informed consent and risks assessment completed.

A formal process is in place of reporting risks, incidents, and trends to ensure analysis, management and timely responses to any identified high-risk issues. Documentation demonstrated the service is identifying, managing, and reporting high impact or high prevalence risks and generally ensuring actions to minimise risks are implemented. The Assessment Team found the service demonstrated improvements in the management of high impact high prevalence risks. Incidents reviewed reflected staff following correct processes, reporting mechanisms, and clinical review and referral of consumers.

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-2)