Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Maculata Place |
| Commission ID: | 3349 |
| Address: | 124 Maculata Drive, SHEPPARTON, Victoria, 3630 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 8 July 2024 to 9 July 2024 |
| Performance report date: | 8 August 2024 |
| Service included in this assessment: | Provider: 1665 Shepparton Retirement Villages Inc  Service: 2107 Maculata Place |

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 Maculata Place (**the service**) has been prepared by Nicola Eastwood, 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 (performance assessment) – 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 31 July 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not Compliant** |

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.

**Standard 3**

* Requirement 3(3)(b) ensure strategies are implemented to adequately monitor, document, and identify safe and effective use of restrictive practices particularly related to the use of psychotropic medications.

**Standard 8**

* Requirement 8(3)(d) ensure governing body oversight of monitoring, reporting and review of the use of restrictive practices, particularly related to the use of psychotropic medications.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

The Assessment Team report identified deficits in the management and prevention of changed behaviours, particularly for consumers subject to chemical restrictive practice. The use of chemical restraint was not reliably recognised and recorded by staff, and indications and directions for its use were not reliably documented. While staff said non-pharmacological interventions are attempted prior to the use of chemical restraint, detailed documentation was not always available to support restraint is used only as a last resort. There were deficits identified in clinical staff understanding of chemical restraint, and the associated risks with restraints had not been documented as discussed with the substitute decision maker. Behaviour support plans did not always include individualised behaviour management strategies and where they did, the service did not demonstrate staff reliably use these strategies. The service did not demonstrate behavioural incidents were always analysed to identify triggers and reduce the risk of recurrence, nor regular evaluation of the effectiveness of chemical restraint.

The Assessment Team report identified examples of consumers subject to chemical restraint who were not included on the service’s psychotropic register, nor indications for the use of chemical restraint and relevant risks recorded. Consumer records did not always reflect that alternative strategies were trialled prior to the administration of medication and behaviour support plans did not show evidence of review following incidents. Consistent evaluation of the use of chemical restraint was not always recorded in a way to reflect the outcome of the review.

The Assessment Team report indicated consumers and representatives are satisfied with the management of risks by staff. Staff demonstrated effective management and prevention of falls, skin injury, pain, and weight loss. This was supported by review of care documentation.

The Approved Provider submitted a response (the response) to the Assessment Team report including supporting evidence and a Plan for Continuous Improvement (PCI). The response indicates that a PCI was provided at the time of the Assessment Contact which included an action to review the psychotropic and restraint registers. The response also indicates this action is ongoing in collaboration with treating practitioners. There is evidence the service has attempted to alter the current clinical management system to include indications for use of chemical restraint. I acknowledge that modifications are not able to be made to the electronic system and encourage the service to ensure indications for use are available at the time of administration of medication.

The response and PCI indicate that updates have been made to the restrictive practice audit tool, with the audit process revised and frequency increased, as well as education to improve the quality of behaviour support plans and documentation. The PCI includes details of actions to improve incident management processes including staff education, review of processes as well as an action to ensure documentation of restraint related risks. Behaviour support plans are to be updated at the time of resident of the day to ensure plans are individualised and contemporaneous.

I note the response disagrees with the Assessment Teams assertion that evidence was not recorded of strategies trialled prior to the administration of psychotropic medication, or review of effectiveness. I accept that there were brief entries in consumer records reflecting immediate strategies and review following administration of medication. I encourage the service to ensure progress note entries reflect the entirety of actions and contain meaningful content. I am reassured that the PCI actions include education to improve the quality of documentation.

I acknowledge the response and supporting documentation which demonstrate progression toward addressing the identified deficits. The impact to consumers is potentially significant where the use of chemical restraint is not adequately monitored, documented or identified. I consider further time is required to ensure the proposed improvements are sustained in practice. As a result, I find this Requirement non-compliant.

# Standard 7

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

Consumers and representatives confirmed staff are competent and possess the skills and knowledge needed for their respective roles. The service collects evidence of staff qualifications and professional registrations, and monitors staff compliance with police checks and relevant legal and professional requirements. Staff receive training in key areas including medication administration, serious incident reporting, infection control, and elder abuse. Clinical staff are required to undergo competency testing in relation to medication administration.

The Assessment Team report included positive representative feedback regarding the skills of staff providing care to consumers living with dementia. Evidence obtained from staff interviews and documentation demonstrated completion of medication competencies, orientation and induction processes, as well as completion of mandatory training.

With consideration to the available information summarised above, I find this Requirement 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. | Not Compliant |

Findings

The Assessment Team report indicated the service has a risk management framework in place, but that it does not effectively manage restrictive practice and its associated risks. Consumer records and documentation was inconsistent, with identified discrepancies across relevant registers and individual consumer medication charts. The service’s psychotropic register did not include adequate detail regarding chemical restraint in use for 2 consumers. The Assessment Team report included information related to specific circumstances where there was no evidence the service had informed a substitute decision maker of the risks associated with the form of restrictive practice and another where restrictive practice was being utilised without the consent of an appropriate substitute decision maker. Risks related to psychotropic medication and chemical restraint are not always identified, monitored, and reviewed by the service.

The Assessment Team found the service’s other processes to manage risk are effective. Staff understand incident reporting and processes are in place to manage incidents. The service reports serious incidents in accordance with legislative requirements, but while some incidents are reviewed and appropriately managed, the Assessment Team report noted behavioural incidents are not always fully investigated.

The services PCI and response to the Assessment Team report refers to actions and improvements relevant to management of restrictive practices consistent with Requirement 3(3)(b). The service has committed to including additional detail related to psychotropic medication reviews in Quality and Safety Committee reporting as well as tabling audit results at the Quality and Safety Committee meetings. The service has now also made education related to psychotropic medication mandatory for all nursing staff and commenced additional toolbox education sessions.

I acknowledge the response and proposed actions contained in the services PCI. I am reassured that the proposed actions will provide greater oversight of the current monitoring and use of psychotropic medications and encourage the service to ensure the governing body continues to be informed of the progress of improvements. While I note the completed actions and updates immediately implemented, I consider further time is required to ensure ongoing monitoring and review of psychotropic medication and chemical restraint. As a result, I find this Requirement non-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)