Performance

Report

**1800 951 822**

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| Name of service: | Maranatha House |
| Service address: | 127 - 137 Whiteley Street WELLINGTON NSW 2820 |
| Commission ID: | 0223 |
| Approved provider: | Maranatha House |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 August 2023 to 9 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 Maranatha House (**the service**) has been prepared by E Woodley, 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.
* the provider’s response to the assessment team’s report received 4 September 2023.
* the Performance Report dated 21 February 2023 following the Review Audit undertaken 18 January 2023 to 20 January 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-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.

* Requirement 2(3)(a) – The approved provider must demonstrate assessment and planning consistently considers risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services. This includes effective processes and practices to consider and mitigate risks associated with psychotropic medication use, chemical restrictive practices, and behaviours requiring support.
* Requirement 2(3)(e)- The approved provider must demonstrate care and services are reviewed for effectiveness on a regular basis, and when circumstances change or incidents impact on the needs, goals or preferences of the consumer. Incidents are investigated to assist in identifying interventions to minimise risk of reoccurrence and to support safe care.
* Requirement 3(3)(a) – The approved provider must demonstrate consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being. Chemical restrictive practice processes are best practice, including used as a last resort after tailored non-pharmacological interventions to manage behaviour are evaluated as not effective, and with informed consent from the consumer and/or representative. Consumer pain is appropriately assessed, managed and monitored to optimise their health and well-being.
* Requirement 8(3)(e) – The approved provider must demonstrate the clinical governance framework implemented at the service is effective in ensuring safe and quality clinical care for consumers, and the minimisation of restrictive practices. This includes best practice regarding restrictive practices including effective review, reporting and consent practices and used as a last resort after non-pharmacological interventions are evaluated as not effective.
* The service has implemented all actions identified in their plan for continuous improvement, submitted in their response to the Assessment Contact report.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the five specific Requirements have been assessed as non-compliant.

The service was previously found non-compliant in Requirement 2(3)(a) and Requirement 2(3)(e) following a Review Audit undertaken 18 January 2023 to 20 January 2023 due to identified deficiencies in assessment and planning, and consideration and review of risks associated with consumer’s care and services.

At the Assessment Contact conducted 8 August 2023 to 9 August 2023, the Assessment Team found while the service had implemented continuous improvement action in response to the identified non-compliance, this had not been effective in ensuring all identified deficiencies in assessment and planning had been rectified. The Assessment Team found that risks associated with psychotropic medication use and chemical restrictive practices had not been considered for all consumers, or explained to the consumer and/or their representative to ensure informed consent was received. For sampled consumers, assessment and planning regarding behaviours requiring support did not consistently include individualised and detailed interventions to inform safe and effective care. The service did not demonstrate effective review of care and services following incidents, including to determine interventions to mitigate risk and ensure safe and effective care. For example, for consumers sampled limited investigation and review of care and services was undertaken following identification of skin injuries, and following changes to behaviours and required support.

The provider’s response to the Assessment Contact report identifies continuous improvement action planned to improve the assessment, planning and review of consumer care and services. This includes improved risk assessment, communication and review processes regarding restrictive practices, and revised incident reporting and investigation procedures. The provider’s response demonstrates that the care and services of consumers identified in the Assessment Contact report have been reviewed to inform safe and effective care.

While the provider’s response demonstrates the service has reviewed the care and services for consumers identified in the Assessment Contact report, I am not satisfied assessment, planning and review of consumer care and services is consistently effective to consider and mitigate risks associated with consumer care and inform safe and effective care and services. The service has not demonstrated effective processes to identify and action gaps in care assessment, planning and review for consumers, and requires times to evaluate the effectiveness of continuous improvement actions implemented.

I find the following Requirements are non-compliant:

* Requirement 2(3)(a)
* Requirement 2(3)(e)

# 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

The Quality Standard is assessed as non-compliant as one of the seven specific Requirements has been assessed as non-compliant.

The service was previously found non-compliant in Requirement 3(3)(a) and Requirement 3(3)(b) following a Review Audit undertaken 18 January 2023 to 20 January 2023 due to identified deficiencies in personal and clinical care delivery including the management of high impact and high prevalence risks associated with this care.

At the Assessment Contact conducted 8 August 2023 to 9 August 2023, the Assessment Team found while the service had implemented continuous improvement action in response to the identified non-compliance, this had not been effective in ensuring effective management of pain and restrictive practices for consumers sampled. For one consumer sampled, the service did not demonstrate effective assessment, management and review of their pain, including when the consumer identified increased levels of pain. When interviewed, the consumer indicated the pain is ongoing and is negatively affecting their health and well-being. The service did not demonstrate effective processes or understanding regarding chemical restrictive practice including identification, informed consent, and use of non-pharmacological interventions.

The provider’s response identifies continuous improvement actions planned to improve processes regarding pain and restrictive practices. This includes staff education and training, identification and emphasis of non-pharmacological interventions, collaboration with medical officers and other health services, and improved assessment, monitoring and review processes.

While the provider has planned continuous improvement action in response to the issues identified in the Assessment Contact report, these actions will take some time to implement and inform clinical practice to result in improvement to consumer care and services.

I find Requirement 3(3)(a) is non-compliant.

While risks associated with chemical restrictive practices were not consistently assessed to inform best practice management, I have considered this in my assessment of Requirement 2(3)(a) and Requirement 3(3)(a). Overall, the service demonstrated the high impact and high prevalence risks associated with consumer’s care are effectively managed. For sampled consumers, risks associated with pressure injuries, falls and infections were identified and managed effectively. Consumers and representatives interviewed by the Assessment Team were satisfied with the management of risks associated with consumer’s care.

I find Requirement 3(3)(b) is compliant.

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Three of the five specific requirements have been assessed and found compliant.

The service was previously found non-compliant in Requirement 7(3)(c), Requirement 7(3)(d), and Requirement 7(3)(e) following a Review Audit undertaken 18 January 2023 to 20 January 2023. At this Review Audit, the Assessment Team found issues regarding staff competency, completion of required orientation and mandatory training, and assessment and monitoring of staff performance.

At the Assessment Contact conducted 8 August 2023 to 9 August 2023, the Assessment Team found staff have completed a suite of competencies aligned with their role, and improved processes for supporting staff education and training have been implemented. Interviews with staff confirmed that they are supported by the service to have the qualifications and knowledge to effectively perform their roles and deliver the outcomes required by the Quality Standards. This included through orientation processes, offered and requested training, and additional assistance to complete and comprehend education and training.

The service demonstrated they have a system to assess, monitor and review each staff members performance. This system includes a performance appraisal booklet where staff self-appraise their work, meet with their manager, and together review their performance in the workforce. Most staff interviewed indicated they have had a performance review in 2023 and management confirmed they were on track with their performance appraisal schedule for 2023.

The provider’s response confirms their commitment to enhancing processes for orientation, training, performance management, competency assessments, and regularly reviewing the roles, responsibilities, and accountabilities of the workforce.

I find the following Requirements are compliant:

* Requirement 7(3)(c)
* Requirement 7(3)(d)
* Requirement 7(3)(e)

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | 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. | Compliant |
| 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 |
| Requirement 8(3)(e) | 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the five specific Requirements has been assessed as non-compliant.

The service was previously found non-compliant in Requirement 8(3)(c), Requirement 8(3)(d), and Requirement 8(3)(e) following a Review Audit undertaken 18 January 2023 to 20 January 2023 due to ineffective organisational governance systems and practices.

At the Assessment Contact conducted 8 August 2023 to 9 August 2023, the Assessment Team found processes were not effective to ensure consistent and effective clinical governance of the care and services for consumers residing at the service. The clinical governance framework provided to the Assessment Team was reflective of clinical policies that did not consistently align with best practice regarding restrictive practices. The organisation did not demonstrate a thorough understanding of restrictive practices and current legislative requirements. The Assessment Team identified while the organisation holds clinical governance meetings, review and actioning of these meeting minutes are not always effective. The organisation demonstrated effective governance for antimicrobial stewardship and open disclosure.

The provider’s response identifies planned improvement to the clinical governance arrangements of the service. This includes review and updating of the clinical governance framework, alignment of policies and procedures to best practice and current legislation, quality assurance including the use of a clinical governance audit tool, and enhanced monitoring and reporting.

While the provider has identified planned improvement to the clinical governance arrangements, these have not yet been embedded to improve clinical outcomes for consumers, particularly regarding minimisation of restrictive practices.

I find Requirement 8(3)(e) is non-compliant.

The Assessment Team found the governance systems implemented at the service were ineffective in relation to regulatory compliance and continuous improvement. The organisation did not demonstrate effective documentation and oversight of service and organisation wide continuous improvement. The Assessment Team identified gaps in the service’s compliance with regulatory responsibilities including the serious incident response scheme (SIRS) and restrictive practices.

The provider’s response includes additional information about the governance systems implemented at the service, including planned improvements to quality monitoring and assurance, and alignment of policies and procedures to best practice and current legislation. The organisation proposes to take a systematic approach to continuous improvement with the development of a continuous improvement plan that is aligned to the organisation’s strategic goals and plans, with clear processes for identifying areas for improvement and regular reporting and communication.

Ineffective clinical governance arrangements and processes to minimise the use of restrictive practices have been considered in my assessment of Requirement 8(3)(e). I am satisfied the provider’s response demonstrates a planned and systematic approach to continuous improvement and regulatory compliance, with oversight and monitoring systems identified. The Assessment Team found other organisational governance systems regarding information management, financial governance, workforce governance, and feedback and complaints were generally demonstrated to be effective.

The Assessment Team found the organisation has a risk management system and framework that informs service operations, is managed by the CEO and overseen by the board. This includes an online risk management system to enable monitoring and reporting of SIRS reports, complaints and key incidents. The service demonstrated processes to ensure high impact and high prevalence risks and incidents of abuse and neglect are reported to the board and CEO for awareness and action. The provider’s response includes additional procedures, staff training, quality assurance, and board oversight planned to enhance the risk management systems at the service.

I find the following Requirements are compliant:

* Requirement 8(3)(c)
* Requirement 8(3)(d)

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)