 Performance

Report

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| Name of service: | McLean Care Mackellar Apex Campus |
| Service address: | 2 Apex Road GUNNEDAH NSW 2380 |
| Commission ID: | 2773 |
| Approved provider: | McLean Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 25 July 2023 |
| Performance report date: | 31 August 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 McLean Care Mackellar Apex Campus (**the service**) has been prepared by G Cherry, 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, 15 and 31 August 2023.
* Performance Report dated 16 March 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | 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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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. | Compliant |

Findings

The Quality Standard was not fully assessed. One of five requirements was assessed and found compliant.

A decision was made on 16 March 2023 the service was non-compliant in requirement 2(3)(a) following a Site Audit conducted from 7-9 February 2023. Previously the service did not demonstrate effective systems to ensure risks are consistently considered in assessment/care planning processes for each consumer particularly in relation to restrictive practices nor ensure individualised behaviour support plans contain recommendations/directives to guide care delivery. In response, several actions were implemented as noted in the plan for continuous improvement (PCI) and via interview with management/executive personnel. These include review of speech pathology assessment/reports, implementation/strengthening admission processes to ensure correct information is documented in care plans (including consideration of risks), Behaviour support plans (BSPs) have been updated to align with external provider recommendations/directives and restrictive practice processes reviewed/updated.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrates effective processes to ensure assessment and planning considers risks to each consumer’s health/wellbeing and informs delivery of safe, effective care/services. Sampled consumers and most representatives consider consumers receive appropriate care/services as per their needs/preferences. Interviewed staff describe assessment and care planning process, how this informs care delivery and specific care needs of individual consumers. Document review detail a comprehensive suite of clinical assessments conducted by registered nursing staff, including risk assessment tools identifying level of risk, subsequent strategies and directives included in BSP’s. I find requirement 2(3)(a) is compliant.

# 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. | Compliant |

Findings

The Quality Standard was not fully assessed. One of seven requirements was assessed and found compliant.

A decision was made on 16 March 2023 the service was non-compliant in requirement 3(3)(a) following a Site Audit conducted from 7-9 February 2023. Previously the service did not demonstrate effective systems ensure consumers personal and clinical care is best practice, tailored to their needs/optimising health and well-being specifically related to management of skin integrity and restrictive practices. In response, several actions were implemented as noted in the plan for continuous improvement (PCI) and via interview with management/executive personnel. These include review of all consumers wounds to ensure no immediate risk, updating of wound management procedure; ongoing improvement of wound management via wound specialist support, regular review by registered nurses and commencement of a nurse practitioner, provision of staff education/training relating to wound management/behaviour support and restrictive practice, review of psychotropic medication, updating of restrictive practice authorisation/consent documentation and implementation of a new electronic monitoring tool.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider consumers receive clinical and personal care as per their needs/preferences; one expressing dissatisfaction however noted a case conference discussion/meeting had been arranged to discuss concerns. Documentation review for sampled consumers detail most wound care aligns with assessment/care planning/directives, however some inconsistencies in recording of wound measurements. Management advised recent purchase of wound care camera to address this and the approved provider’s response details implementation of a new wound recording/management process. Processes to ensure monitoring/review and referral in relation to unplanned weight loss is evident.

Behaviour support plans (BSP’s) generally detail individualised interventions/strategies, pain and diabetic management occurs in line with medical officer directives. However, the assessment team note effective systems to ensure oversight of restrictive practices for consumers residing in the memory support unit (MSU) were not evident. Observations by the assessment team note some staff not demonstrating knowledge relating to all aspects of restrictive practice due to locking some consumers bedroom doors resulting in consumers not supported to freely exit/enter their individual rooms. The service did not identify this as restrictive practice and management personnel were not aware this was occurring. Upon bringing it to their attention they undertook to immediately rectify the issue, contact representatives, and complete an internal investigation. In addition, the assessment team observed assistance is required from staff to enable entry/exit to the service via the front door. Management advised awaiting contractors to install a device to enable independent entry/exit.

In their response, the approved provider acknowledges inappropriate restrictive practice within the MSU noting preliminary investigations identified this practice within one unit/ nor for an extended period. Actions include immediate unlocking of doors and clinical review (medical officer reassessment) of consumers involved (noting personal care continued as required). The CEO contacted all representatives to implement open disclosure practices, ensured subsequent reporting as per legislative requirements and provision of enhanced education delivered to all staff - noting restrictive practice education a mandatory education requirement.

In consideration of compliance, while I acknowledge the service demonstrates effective systems relating to some aspects of restrictive practice, I am concerned previous staff education/training (as mentioned by the approved provider in their response) did not ensure staff knowledge/awareness of legislative requirements. However, I accept immediate responsive actions (including assessment of consumers to ensure safety), unlocking of doors, plus re-education staff training, and the approved provider’s commitment to ongoing organisational led monitoring processes to safeguard against re-occurrence.

I find requirement 3(3)(a) is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:  (i) antimicrobial stewardship  (ii) minimising the use of restraint  (iii) open disclosure. | Compliant |

Findings

The Quality Standard was not fully assessed. One of five requirements was assessed and found compliant.

A decision was made on 16 March 2023 the service was non-compliant in requirement 8(3)(a) following a Site Audit conducted from 7-9 February 2023. Previously the service did not demonstrate a clinical governance framework (including policies/procedures) is effectively implemented specifically in relation to some restrictive practices. In addition to improvements details in requirement 3(3)(a), internal doors to all areas except the MSU are unlocked to allow free movement/access for consumers who reside outside of the MSU.

During this assessment contact information was gathered through interviews, observations, and document review. Effective systems in relation to some aspects of this requirement were evident, for example, an organisational risk management framework including policy/procedural guidance in relation to antimicrobial stewardship (AMS) and practices relating to open disclosure principles. Observations by the assessment team note consumers residing in the MSU are not supported to freely exit/enter their rooms due to staff locking bedroom doors, [consideration is given in requirement 3(3)(a)].

In their response, the approved provider acknowledges inappropriate practice within the MSU, immediately unlocked bedroom doors, communicated with representatives of consumers involved, ensured subsequent reporting as per legislative requirements. In consideration of compliance, I acknowledge the service demonstrates effective organisational systems relating to antimicrobial stewardship, open disclosure processes and some elements of restrictive practice.

I find requirement 8(3)(e) is compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)