Performance

Report

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| Name of service: | Meadow Heights Care Community |
| Service address: | 90 Lightwood Crescent MEADOW HEIGHTS VIC 3048 |
| Commission ID: | 3535 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 August 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 Meadow Heights Care Community (**the service**) has been prepared by C Spiller, 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

# 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 5** Organisation’s service environment | **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 |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |

Findings

The service was found non-compliant with Requirement 2(3)(a) following a Site Audit conducted 9 August 2022 to 12 August 2022. The Assessment Team found the service did not demonstrate assessment and planning considered risks to the consumers health and well-being and identified varying degrees of deficits and gaps in assessment and planning, particularly with changed behaviours.

During the Assessment Contact conducted on 2 August 2023 management explained the service has implemented a range of actions in response to the non-compliance in Requirements 2(3)(a) and 2(3)(b) identified at the previous Site Audit which have led to improvements. Improvements have included;

* review of Behaviour Support Plans, reformatted documentation and procedure developed and implemented
* four monthly audit of residents’ care plans to ensure consent for administration of psychotropic medications is provided by the residents or appropriate representative
* ‘It takes a Village’ initiative to ensure a whole of team approach to mitigate identified risks and enhance resident’s wellbeing and quality of life
* tailored staff education program including dysphagia, responsive behaviour management, new Behaviour Support Plan (BSP) process, informed consent, recognizing high impact high prevalence (HIHP) residents
* a review of all NDIS documentation
* regular communication with NDIS coordinators to strengthened relationships
* behaviour support plans to be completed for all new admission and to available on the service’s electronic management system.

All consumers and representatives interviewed expressed satisfaction with the assessment and care planning processes used to inform the delivery of care. Management advised behaviour management care plan are now completed for every new consumers with reviews scheduled to occur every 4 months as part of the care plan evaluation process. For consumers who receive funding and supports under the National Disability Insurance Scheme (NDIS) a behaviour management care plan is developed to integrate with their NDIS behaviour management plan. Clinical staff demonstrated knowledge of consumers’ risks and described strategies used to ensure care is effective and minimise identified risks. Management advised a resident admission pathway, is followed to ensure all risks are identified prior to the consumer entering the service. Consultation with consumers and their representatives, allied health professionals also inform the delivery of safe and effective care.

The service was found non-compliant with Requirement 2(3)(b) following a Site Audit conducted 9 August 2022 to 12 August 2022. The Assessment Team found care information for some consumers was conflicting and outdated. Specifically for one consumer whose goals and preferences were not reflected in their care plan and the mobility and transfer equipment did not align with current assessed needs.

All consumers and representatives interviewed confirmed they had taken part in discussions about consumers’ current needs and preferences. Management described processes for discussing end of life planning and the medical practitioner works in partnership with clinical staff to inform and advise consumers and representatives if they have questions. Care documentation reviewed confirmed the service regularly consults with consumers and their representatives to discuss care plans including changes to care needs during the monthly ‘it takes a village’ review and the 4 monthly full care plan review. The Assessment Team observed consumers goals and preferences documented in electronic care plans to be current.

Accordingly, with the information available, I assess the service as now compliant with Requirements 2(3)(a) and 2(3)(b).

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

Findings

Requirement 3(3)(a) was found non-compliant following a Site Audit from 9 August 2022 to 12 August 2022. The service was unable to demonstrate it provided consistent best-practice care specifically in relation to use of psychotropic medications.

During the Assessment Contact conducted on 2 August 2023, consumers and representatives interviewed were satisfied the service provided effective person-centred clinical care. Care documentation reflected ongoing assessment, monitoring, and evaluation of care provided to consumers subjected to chemical restraint and the use of psychotropic medications. Management and staff described how they review consumers’ assessments and care plans in consultation with consumers and/or their representatives with input from a multidisciplinary health team. The Assessment Team reviewed the service’s restrictive practice register and psychotropic medications register. Each consumer who was subject to restrictive practices had documented evidence their representative had given informed consent for the use of the restraint and the care plan review demonstrated individualised behaviour support plans were in place to minimise the use and impact of the restraint upon consumers. Similarly, the psychotropic medication logbook included psychotropic medication management forms completed for each consumer. The service has implemented a number of improvement actions, which have been effective including;

* review of Behaviour Support Plans, reformatted documentation and procedure developed and implemented
* four-monthly audit of residents’ care plans to ensure consent for administration of psychotropic medications is provided by the residents or appropriate representative
* ‘It takes a Village’ initiative to ensure a whole of team approach to mitigate identified risks and enhance resident’s wellbeing and quality of life
* tailored staff education program including dysphagia, responsive behaviour management, new Behaviour Support Plan (BSP) process, informed consent, recognizing HIHP residents.

Requirement 3(3)(b) was found non-compliant following a Site Audit from 9 August 2022 to 12 August 2022. The service was unable to consistently demonstrate effective management of high impact or high prevalence risks (HIHP) associated with swallowing difficulties and challenging behaviour.

During the Assessment Contact conducted on 2 August 2023, clinical management explained the service has implemented a range of actions in response to the non-compliance identified at the previous Site Audit which have led to improvements and are described above.

During the Assessment Contact conducted on 2 August 2023, the service demonstrated effective management and clinical oversight of high impact and high prevalence risks associated with falls and responsive behaviours. All interviewed consumers and representatives were satisfied the service effectively manage the risks for consumers. Staff and management described HIHP for consumers at the service are effectively managed through clinical data monitoring, trending, and risk mitigation strategies for individual consumers. HIHP risk assessment is embedded into the care planning process for each consumer. The service has mobility and fall management and prevention policies and processes in place guiding the staff to provide safe and individualised care. Falls prevention and fall management education are provided to care staff and HIHP risks associated with falls are discussed at the daily ‘leadership team’ meeting, at handover time and weekly case study conducted with care and nursing staff.

In light of the information provided to me and summarised above, I find Requirements 3(3)(a) and 3(3)(b) are compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service was found non-compliant with this requirement following a Site Audit conducted from 9 August 2022 to 12 August 2022. The service at that time did not demonstrate provision of safe and suitable equipment for a consumer.

The service has implemented the following actions in response to the deficits previously identified. These actions included:

* review of all equipment in the service
* liaison with NDIS regarding specific equipment requirements for NDIS consumers
* liaison with physiotherapist or occupational therapist to ensure correct equipment in place for consumers
* sling register has been reviewed and labelled

During the Assessment contact conducted on 2 August 2023, the service demonstrated improved processes to ensure safe and suitable equipment. The Assessment Team viewed documents and observed processes to support the improvements implemented.

With the information available to me from the visit, I am satisfied the service has implemented improvements to address the non-compliance. Therefore, I find the service compliant with this Requirement.

# 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 following a Site Audit conducted from 9 August 2022 to 12 August 2022. The service at that time did not demonstrate effective management of high impact high prevalence risks and supporting consumers to live the best life they can.

The service has implemented the following actions in response to the deficits previously identified which have led to improvements. The actions have included:

* provision of ‘understanding dementia’ webinar, conducted by the organisation’s dementia specialist. The webinar is available for staff, and representatives to participate.
* Implementing a holistic approach with regards to care needs of consumers, referred to as the ‘It takes a Village’ initiative where all heads of department are involved in identified consumers care and service needs.

During the Assessment contact conducted on 2 August 2023, the service demonstrated improved risk management of HIHP of consumers and management of changed behaviours.

Management said the organisation has an established system and processes for identifying and managing HIHP risks associated with the care of consumers. Management outlined current high-risk areas include changed behaviours and falls. Following falls incidents, consumers are reviewed by physiotherapist, with falls prevention strategy recommendation to guide staff.

Management said that the monitoring of incidents occurs with incidents being recorded and analysed. Following any SIRs reportable incidents, a detailed case study will be conducted.

The service supported staff in relation to responsive behaviours through toolbox sessions on behaviour management. ‘Understand SIRs - educate to difference between priority 1 and 2 - reporting to appropriate person’ toolbox sessions was conducted in July 2023 and Managing behaviours.

The Assessment Team reviewed the SIRs register which demonstrate the incidents are reported within required timeframe. Staff said they know their role and responsibility in this regard and its escalation process when required.

With the information available to me, and the improvements actions undertaken, I find the service is compliant with this Requirement.

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)