Performance

Report

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| Name: | Meercroft Care |
| Commission ID: | 8788 |
| Address: | Clements Street, DEVONPORT, Tasmania, 7310 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 31 October 2023 to 1 November 2023 |
| Performance report date: | 13 December 2023 |
| Service included in this assessment: | Provider: 1226 Meercroft Care Inc  Service: 5072 Meercroft Care |

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 Meercroft Care (**the service**) has been prepared by Phuong Lang, 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 20 November 2023.

# 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 | **Not Compliant** |
| **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.

**Standard 3**

* Requirement 3(3)(b) evaluate and monitor post falls management staff knowledge and improvement.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

The service was previously non-compliant with this standard following a site Audit in December 2022. The Assessment Team noted several improvement actions implemented since the site audit specifically related to managing risks to prevent harm to consumers and staff.

Consumers confirmed they were supported to take risks to enable them to live life as best they can. Staff explained consumer choices are assessed for risk at entry and reassessed regularly or as consumer preferences or capacity changes. The service’s policies and practices support consumers to pursue activities that may have an element of risk.

There have been improvements made to the outdoor smoking area which included shelter, seating, call bell access, an ashtray, flameless lighter, individual smoking aprons, fire blanket, extinguisher, and secure fencing.

A review of care documentation reflected assessments and risk enablement forms for use of electronic scooters and the external smoking area.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 1(3)(d)

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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 |
| 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. | Compliant |

Findings

The service was previously non-compliant with this standard following a site Audit in December 2022. The Assessment Team noted several actions have been implemented since the site audit specifically related to discussions around care planning and review and changes to consumer care needs including end of life.

The Assessment Team noted engagement with consumers and/or representatives in the care planning process, however, end of life documentation was inconsistent due to a backlog in completing reviews. Clinical staff explained as part of the care plan review, they review the last 3 months of a consumer's progress notes, medical officer notes, weight loss, skin integrity, changed behaviours and changes to wounds assessments. Where end of life planning was in place consumers confirmed their wishes were considered and where challenging behaviours were identified assessments and care planning reflected adequate interventions.

Consumers and representatives confirmed they are kept informed regarding changes to consumer health including when incidents occur. Care planning documents demonstrate care and services are regularly reviewed for effectiveness or following an incident which affects consumer needs. Staff described the review checklist and process for regular consumer review and when changes occur. Clinical staff confirmed the frequency of reviews and discussions with consumers and representatives with any changes communicated to staff and other service providers if required.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirements 2(3)(b) and 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The service was previously non-compliant with Requirements 3(3)(a), 3(3)(b), 3(3)d), 3(3)(e) and 3(3)(f) following a site Audit in December 2022. The Assessment Team noted several effective improvement actions have been implemented since the site audit however the Assessment Team consider requirement 3(3)(b) remains non-compliant as post falls management did not align with best practice and the services policy.

Requirement 3(3)(b):

The Assessment team reviewed documentation for consumers who had experienced a recent fall. Neurological observations were not carried out in accordance with the services policy or aligned with best practice and although pain was initially assessed at the time of the fall, although no additional commencement of a 3-day pain chart was commenced according to the service’s policy.

Management identified scheduled auditing of high impact or high prevalence risk management, according to the service’s Plan for Continuous Improvement (PCI) had not been completed. Following feedback management acknowledged inconsistencies with clinical processes related to falls management and committed to further training for staff to ensure knowledge of correct procedure.

The Assessment Team noted the service demonstrated effective management of changed behaviours, and unplanned weight loss.

The Approved Provider submitted a response to the Assessment Teams report with a copy of the PCI with actions related to post falls management, evidence of toolbox discussions and communication to staff regarding daily duties to be attended.

I acknowledge the response and supporting evidence provided, however consider further time is required to adequately evaluate staff knowledge and improvement of practice related to recording and conducting adequate post falls monitoring. As a result, I find this requirement non-compliant.

Compliance with remaining Requirements:

Staff described personalised and clinical care that aligned with best practice. The Assessment Team identified some inconsistency in wound care documentation but noted that the available evidence indicated effective clinical care, with wounds continuing to heal. Pain management documentation reflected appropriate assessment and evaluation with effective pain management strategies provided in collaboration with consumers and health professionals. The Assessment Team noted some inconsistency in documentation related to informed consent and regular review of chemical restrictive practice. However, psychotropic medications for the purpose of modifying changed behaviours were correctly identified as subject to chemical restrictive practice.

Clinical staff described how deterioration or changes in consumer condition such as behaviours, and acute change in care needs are identified, actioned, and communicated. Documentation reflected appropriate actions taken in response to deterioration or change in a consumer’s health status. There was evidence of allied health contribution and review by externally sourced specialty services was evident.

Staff and allied health professionals demonstrated knowledge of consumer needs and preferences and described the various methods in which information is communicated. This was supported by the Assessment Teams observations at the time of attendance with interactions noted between staff, representatives, allied health, local health services and other health professionals. There is an escalation and referral processes in place to support consumers experiencing mental health issues, although the service has experienced some challenges related to their regional location.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service non-compliant with this standard.

# 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 has an effective electronic risk management system supported by an incident management and procedures policy. However, this policy did not initially identify unlawful or inappropriate sexual conduct as a Serious Incident Reporting Scheme (SIRS) priority one reportable incident. Management and staff explained the system and outlined their reporting responsibilities, based on their position. Management and staff provided examples of risks identified and investigated, and education provided to ensure risks to consumers are minimised. Incidents identified as consumer abuse and/or neglect are appropriately reported.

Staff described the process for reporting incidents as a stepped approach with the initial reporting completed by the person involved. Management described how consumers are supported to take informed risks, to live the life they desire, by informing the consumer and/or their representative of the risks involved and completing a form documenting acknowledgement.

The Assessment Team noted an example of appropriate SIRS reporting and following feedback, the service updated their incident management and procedures policy to correctly reflect unlawful or inappropriate sexual conduct as a SIRS priority one reportable incident.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with 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)