Performance

Report

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| Name of service: | Melaleuca Home For The Aged |
| Service address: | 71-73 Mary Street EAST DEVONPORT TAS 7310 |
| Commission ID: | 8820 |
| Approved provider: | Melaleuca Home for the Aged Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 June 2023 to 22 June 2023 |
| Performance report date: | 27 July 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 Melaleuca Home For The Aged (**the service**) has been prepared by N 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 - 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 17 July 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 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.

**Standard 2**

* 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.
* 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.

**Standard 3**

* 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.

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

**Standard 8**

* 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 managing and preventing incidents, including the use of an incident management system.

* 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.

# 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)(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. | Non-compliant |

Findings

The service was previously found non-compliant with requirement’s 2(3)(a), 2(3)(b), following a Site Audit performed between 24 May to 27 May 2022. At the time of the Site Audit the service was unable to demonstrate:

* assessments and care plans were current or completed, resulting in a lack of documentation to guide staff in providing care, and
* assessments and care plans did not address palliating needs, resulting in a lack of documentation to guide staff in providing care.

At this site visit the Assessment Team noted the service have implemented some improvements. However, assessments and care plans did not consistently provide adequate information to mitigate risk or to ensure the safe delivery of care in relation to a range of care areas and assessment and care planning had not been implemented for consumers who required palliative care.

With regard to requirement 2(3)(a) the Assessment Team noted consumers with care needs including restrictive practice, diabetes, dialysis, fluid restriction, pain, palliative care, wounds, and indwelling catheters did not have appropriate or current assessments and care plans completed to guide staff. The service utilised a white board to alert staff to complex care procedures including insulin administration and catheter care. However, the Assessment Team noted it is not current or accurate. Multiple diabetic consumers did not have completed diabetic management plans, a consumer with complex clinical care needs did not have adequately documented care planning related to treatment received external to the service. There was inadequate respite care documentation related to clinical needs and incomplete authorisation and documentation for the use of restrictive practices.

The Approved Provider submitted a response (the response) and Plan for Continuous Improvement (PCI) which provides further context, evidence of implemented actions to address these concerns and future planning. However, the nature of these deficits is significant in ensuring the continuity of care and safety for consumers and further understanding of the need for accurate and contemporaneous documentation is required.

With regard to requirement 2(3)(b) assessment and care planning has not been implemented for consumers who the Assessment Team noted were palliative. Advanced care planning was not always completed appropriately or in a timely manner. Management was unable to identify any consumers requiring palliative care at the time of entry however the Assessment Team confirmed there were consumers receiving palliative treatment as identified on handover sheets. However, no palliative care assessments or care plans are completed, no proactive assessment of pain has occurred. No pain charting or assessment has been implemented and advance care directives are incomplete or inadequate. A sample of advanced care directives reviewed by the Assessment Team, indicated the forms are incomplete, incorrectly witnessed or not signed by the medical officer. Assessments and care plans were not reflective of current care needs. The service did not ensure changes to consumers documentation, used to guide staff, were completed when care needs and strategies change.

The response and PCI submitted, provides evidence of implemented actions and future commitment to ensuring improvement in current practice. Notwithstanding this and the completion of required assessments as identified by the Assessment Team it continues to be of significant concern that these deficits are consistent with previously identified non-compliance. Specifically, consolidation of actions and sustained improvement is required in the documentation of complex clinical care needs, pain, and diabetes management, recognising palliative care requirements and the need for individual risk assessments when supporting consumer choice outside of clinical recommendations.

While acknowledging the work completed by the service following the Assessment Teams observations and with consideration to the potential impact on consumers if similar circumstances of non-compliance continue to arise, I consider further time is required to ensure these improvements are imbedded in practice.

As a result, and with consideration to the available information I find these requirements are not 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |

Findings

The service was previously found non-compliant with requirement’s 3(3)(a), 3(3)(b), 3(3)(f), following a Site Audit performed between 24 May to 27 May 2022. At the time of the Site Audit the service was unable to demonstrate:

* adequate restrictive practices and wound management,
* adequate diabetes, falls management and management of unplanned weight loss,
* consistent timely and appropriate referrals.

The Assessment Team noted some overall improvements related to the previously identified deficits; however previously proposed actions have been inadequate to address these non-compliances.

With regard to requirement 3(3)(a) the Assessment Team noted some improvements relating to aspects of restrictive practices, skin, and wound care. However, the service was not able to demonstrate pain was managed effectively, wound assessments were not consistently completed, and wound measurements were not taken or recorded. The Assessment Team also noted incidents of mechanical restraint being used outside its authorised use. The service did not demonstrate consumer pain is managed effectively. The service is not identifying, actioning, and reviewing pain in a timely manner. Pain management was frequently reactive and there no consideration to implement pharmacological and non-pharmacological strategies to prevent the regular reoccurrence of pain. Pain assessment and charting is not consistently completed when pain is identified. The Assessment Team noted inconsistent completion of documentation related to restrictive practices and inappropriate use of mechanical restraint.

The Approved Provider submitted a response (the response) and Plan for Continuous Improvement (PCI). The response includes information related to implemented actions and future planning to address the concerns raised by the Assessment Team. I do not accept that the use of equipment to restrain a consumer, particularly without additional risk assessment, safe practice, or appropriate use of equipment. It is accepted that the relevant assessments and documentation for identified consumers has now been completed, however it is apparent that access to clinical staff has impacted the ability for this service to maintain and sustain the completion of contemporary records, updates, and changes to clinical care.

With regard to requirement 3(3)(b) there was evidence to support that diabetes management is not consistently implemented in accordance with the medical officer’s directives. Prescribed as required insulin was not administered when indicated, Blood Glucose Level’s (BGL’s) were not taken as directed and those readings outside of reportable ranges were not consistently reported. Some consumers did not have diabetes management plans in place or medical officer directives. Post falls management was not consistent with the service policy and incidents of weight loss were not identified and actioned in a timely manner.

The response and PCI indicate the falls management policy is under review and there have been some discrepancies with formal diabetes diagnoses and requirements for BGL monitoring. While I acknowledge this may be the case, the documentation available to the Assessment Team did not reflect further investigations or queries related to the need for ongoing BGL monitoring. Additionally, documentation of post falls observations should be available in a centralised location to ensure continuity of care.

With regard to 3(3)(f) although the service has implemented a range of improvements, they have not resulted in sustained improvements. The Assessment Team noted timely referrals are not consistently occurring. The Assessment Team did observe examples of referrals occurring to a range of allied health specialists and external support, there was inconsistency as identified by the lack of referral to a dietitian in a timely manner.

The response and PCI submitted by the Approved Provider includes evidence of implemented actions and future commitment to ensuring improvement in current practice. Notwithstanding this submission, completion of assessments and documentation for identified consumers, it continues to be of concern that consistent areas of non-compliance are apparent. I note the response which indicates monthly weight reviews for identified consumers at risk and referral process in the same month to a dietician, as well as the implementation of an electronic medication system to address previous issues with hard copy medication charts. Despite these assertions and additional information, further time is required to ensure improvements continue to be implemented in practice.

As a result, and with consideration to the available information I find these requirements are not compliant.

# 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. | Non-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 service was previously found non-compliant with requirement’s 8(3)(d), 8(3)(e), following a Site Audit performed between 24 May to 27 May 2022. At the time of the Site Audit the service was unable to demonstrate:

* effective risk management framework to provide clinical oversight of high-impact or high-prevalence risks associated with consumer care, effective risk management systems and practices to identify, review and manage clinical risks such as skin integrity, wound management, falls, choking episodes and weight loss, and
* effective processes and work practices to minimise the use of restraints, including identifying risks associated with chemical and mechanical restraints.

With regard to requirement 8(3)(d) the service has implemented several actions in response to the previously identified non-compliance including strategic oversight by the Board, an electronic medication management system to reduce errors, weight loss and falls through electronic management, additional staffing to oversee the completion of documentation and electronic Blood Glucose Level (BGL) monitoring. Although the service demonstrated a range of actions implemented to action their non-compliance, the Assessment Team noted deficits continue to occur in clinical care. There was ongoing evidence of failure to prepare adequate diabetes management plans, adequately monitor consumer BGL’s and administer insulin therapy as required. Continued failure to develop an assessment, care plan or process to monitor requirements associated with external sources of treatment and associated clinical treatment recommendations and inadequate knowledge of poor staff practice related to medication incidents and monitoring post falls. Pain management remains of concern, lacking adequate consideration of pharmacological and non-pharmacological strategies to address reports of pain.

The Approved Provider submitted a response (the response), and Plan for Continuous Improvement (PCI) indicating that due to discrepancies in formal diabetes diagnoses for some consumers this has contributed to an inability to complete required assessments and planning to support clinical oversight of high impact or high prevalence risks. Notwithstanding this assertion and additional information surrounding medication and pain management as well as post falls monitoring processes, the available evidence demonstrates that the risk management framework has not been adequate to support effective clinical oversight as these deficits continue to be consistent with previously identified areas of non-compliance and have not been adequately addressed to date.

With regard to requirement 8(3)(e) the service has implemented several actions in response to the previously identified non-compliance including an organisational clinical governance framework demonstrated in a formal policy, a restrictive practice policy reflecting best practice to minimise use of restraint as well as training and staff training, and education related to legislative requirements associated with the use of restraint. However, the service continues to be unable to demonstrate how these policies and actions have been implemented in practice. The Assessment Team noted inappropriate use of mechanical restraint as well as the inability to recognise the use of equipment as a form of restraint contrary to best practice and incomplete assessments and authority for use of chemical restraint.

The response and PCI submitted by the Approved Provider does not recognise that the use of equipment to restrict the movement of a consumer is a form of mechanical practice. The response does indicate that there has been updates to chemical restraint documentation and associated authorities reviewed. I accept that the service has now completed incomplete documentation, however, continue to be concerned that these deficits are consistent with previously identified areas of non-compliance.

While I acknowledge the service’s response and completed actions, there continues to be concerns with the current risk framework and capacity to support effective clinical oversight. Further time is required to ensure the identified improvements and planned actions are maintained in practice and there is further consideration to understanding the principles of minimising and identifying the use of restraint.

As a result, and with consideration to the available information I find these requirements are not 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)