Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Mercy Place Colac |
| Service address: | 83-99 Queen Street COLAC VIC 3250 |
| Commission ID: | 3011 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 February 2023 to 22 February 2023 |
| Performance report date: | 3 April 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 Mercy Place Colac (**the service**) has been prepared by D Utting, 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 approved provider’s response to the assessment team’s report received 20 March 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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

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 3(3)(a) - the approved provider ensures consumers with clinical care needs such as wounds, pain or identified as requiring a restrictive practice are assessed, monitored and regularly reviewed. Consumers with responsive behaviours are assessed and have a tailored behaviour plan documenting behaviour triggers and individualised strategies to enable staff to optimise health and wellbeing.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 |

Findings

Requirement 3(3)(a) was found non-compliant following a site audit conducted between 22 March 2022 and 25 March 2022. The service was not able to demonstrate consumers requiring wound care or restrictive practices received safe and effective clinical care and that was best practice. The identified deficits included:

* wound care planning documents did not include regular measurements or photographs.
* care planning documents evidenced ‘as necessary’ psychotropic medication was administered without consent and with no documented evidence of non-pharmacological strategies trialled.
* restraint authorisation forms were out of date.

At the February 2023 assessment contact the Assessment Team found ongoing deficits in the use of restrictive practices which were not in line with legislative requirements. Some improvements have been made in obtaining and documenting consent and authorisation of restrictive practices for individual consumers. For some consumer’s sampled documentation reviewed evidenced non-pharmacological strategies being trialled with consumers prior to the administration of ‘as necessary’ psychotropic medication.

However, for some consumers sampled, there was inconsistency in documenting behaviour management information. Behaviour management strategies documented were not always tailored to the individual, did not include information about the chemical restrictive practices and guidance for staff in what circumstances to administer the medication. Staff interviewed described generic behaviour management strategies which included identification of unmet needs such as toileting, nutrition and hydration, but could not describe individualised triggers and strategies for the sampled consumers. For one consumer there was inconsistent information documented about the use of a psychotropic medication. Staff confirmed the medication had not been administered since December 2022 due to an overall decline in the consumers health and no review of medication was evident. Representatives interviewed were not aware of behaviour support plans or individualised management strategies being used to support consumers.

The approved provider submitted a written response with supporting information including updated care planning documents, consent forms, progress notes and updated consumer information on the Restrictive Practice Resident Record (RPRR). There is a ‘Compliance Action Plan’ to review all consumer behaviour care plans to ensure they are individualised and tailored by the end of April 2023. I note that while the approved provider’s electronic care planning system will be upgraded in 2023 with enhancements to the management of restrictive practices and behaviour support plans, this is not yet in place. The approved provider’s response did not persuade me that the service was effectively tailoring or optimising care for the consumer that had ceased the use of a psychotropic medication.

At the assessment contact the Assessment Team found the service demonstrated improvements to wound and pain management. Consumers interviewed were satisfied with how their pain was managed. Overall, for the consumers reviewed, wound and pain management was found to be safe with effective systems in place to assess, monitor, treat and review consumers. Wound care documentation evidenced wound photos and measurements and implementation of strategies and pain management consistent with consumer pain care plans. Clinical staff undertake monthly analysis, trend reporting and audits to ensure staff compliance with the wound management processes.

I have considered the Assessment Team report and the approved provider response. I am not satisfied the approved provider has demonstrated it has implemented and embedded effective improvements in relation to consumers with responsive behaviours. The service has not demonstrated that that consumers subject to chemical restrictive practices have a behaviour support plan identifying triggers and individualised strategies. Furthermore, improvements in the consistent use of the service’s own restrictive practices documentation to record consumers subject to a restrictive practice is yet to be evaluated. I find Requirement 3(3)(a) is Non-compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Requirement 5(3)(b) was found non-compliant following a site audit conducted 22 March 2022 to 25 March 2022. The service was unable to demonstrate that the furniture, fittings, and equipment were safe, clean, well maintained, and suitable for the consumers.

At the Febraury 2023 assessment contact the Assessment Team found that the approved provider has implemented a range of effective corrective actions in response to the non-compliance found at the site audit.

Consumers and representatives expressed satisfaction with the cleanliness of the service and the responsiveness to maintenance requests. Consumers said they are able to freely access the indoor and outdoor areas.

The service is utilising a range of systems for preventive, scheduled maintenance and an electronic tracking system for ad-hoc maintenance requests monitored by manager and maintenance staff. Cleaning schedules include daily task lists and schedule for deep cleaning of consumers’ rooms.

The service environment was observed by the Assessment Team to be free of clutter and enabling safe movement of consumers inside and outside. Equipment was observed to be stored in designated areas adjacent to common areas and hallways and in a storage shed outside.

Based on the available evidence I am satisfied that the service is providing an environment that is uncluttered and clean, facilitating the free movement of consumers. I find Requirement 5(3)(b) Compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

Requirement 7(3)(a) was found non-compliant following a site audit conducted between 22 March 2022 and 25 March 2022. The service did not demonstrate sufficiency in workforce numbers to ensure the delivery of safe and quality care and services. Consumers stated lack of staffing impacted their care and services.

At the Febraury 2023 assessment contact, the Assessment Team found that the service has implemented improvements to address the deficits identified at the previous site audit.

Consumer and representatives said they were satisfied with staffing levels and call bell response times. Consumers said that staff are busy but are there to help when they need. Representatives interviewed expressed satisfaction with the improvements in staff responsiveness and said consumer care had improved as a result.

Corrective actions outlined in the Assessment Team report includes offering permanent shifts to casual and part-time staff, recruitment of additional staff, management of leave to ensure critical staffing levels are maintained, orientation program for new staff and increased management oversight of staffing issues. Staff interviewed said that management had implemented improvements to increase the numbers of staff available, including the use of agency staff to cover unfilled shifts. Roster and allocation documentation reviewed by the Assessment Team demonstrated that an appropriate mix of skill and roles are planned and allocated throughout the service, nursing shifts allocated and use of agency and permanent staff to cover unallocated shifts. The Assessment Team observed staff responsiveness to call bells and consumers being assisted to access activities of daily living.

Based on the available evidence, I am satisfied the service has in place systems and processes for a planned workforce and will continue to implement continuous improvement actions. I find Requirement 7(3)(a) is Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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 |

Findings

Requirement 8(3)(c) was found non-compliant following a site audit conducted between 22 March 2022 and 25 March 2022. The service was unable to demonstrate:

* effective regulatory compliance governance systems specifically in relation to the reporting requirements of the Serious Incident Response Scheme (SIRS) and management of psychotropic medications.

At the February 2023 assessment contact the Assessment Team found the service has implemented improvements to address the deficits identified:

The service has implemented processes to ensure serious incidents are identified, reported appropriately, analysed and used for continuous improvement. Staff training records sighted by the Assessment Team evidence staff training about SIRS. Clinical staff described how they review progress notes every morning to ensure all incidents have been identified and quality manager determines SIRS reporting requirements and supports staff with completion of incident reporting. Management said the ongoing involvement of the quality officer has built staff capacity in relation to SIRS and the requirements associated with the use of psychotropic medication/chemical restraint. Monthly trending and analysis of all clinical incidents including SIRS is presented at the services’ leadership meetings and actions for improvement are identified and monitored.

Based on the available evidence summarised above, I am satisfied that the service has effective governance systems in place. The service has made improvements to the processes to ensure they meet the regulatory requirements in relation to SIRS. I am satisfied the approved provider will continue to embed these improvements into usual practice. I find Requirement 8(3)(c) 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)