Performance

Report

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| Name of service: | Mercy Place East Melbourne |
| Service address: | 22 Verona Lane EAST MELBOURNE VIC 3002 |
| Commission ID: | 3837 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 November 2022 |
| Performance report date: | 22 December 2022 |

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 East Melbourne (**the service**) has been prepared by L Glass 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 30 November 2022

# 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 | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **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 6** Feedback and complaints | **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.

* Assessment and planning is undertaken for all consumers and considers the risks to the consumers and documents to information needed to implement and deliver safe and effective care including complex care and strategies to manage responsive behaviour.

**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)(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**

Following a Site Audit undertaken 14 to 22 December 2021, the service was found to be non- compliant with two Requirements in Standard 2, 2 (3)(a) and 2 (3)(e). For Requirement 2 (3)a, the service was unable to effectively demonstrate compliance in relation to consideration of risks to inform delivery of effective care and services to address consumer behaviours and skin integrity. For Requirement 2(3)e the service did not demonstrate effective review of consumer incidents with appropriate action and review of care and services with change of circumstance, particularly in relation to weight loss and pain management.

At the Assessment Contact undertaken on 8 November 2022 for Requirement 2 (3)(a) the Assessment Team found in response to the previous non-compliance, the service had undertaken education for clinical staff about assessment and care planning with a focus on skin care and behaviour management. Reviews of consumers identified as at high risk were undertaken and the service conducts weekly clinical meetings to identify and analyse risks and trends.

However, the Assessment Team found the service did not demonstrate effective assessment of risk and planning of care in relation to falls, pain and changed behaviour, particularly for one consumer, impacting the care of the consumer. The Assessment Team identified gaps in assessment and planning and inconsistent documentation of directives to inform the delivery of safe and effective care and inconsistent consideration of risks to inform care. For example, it is unclear when the consumer entered the service as two dates were provided for mid-year 2022. The most recent update to the consumer’s pain care plan was dated late August 2022. The care plan for the consumer did not effectively guide staff in how to identify and assess the consumer’s pain and no specific directive was documented about the appropriate approach to use. Pain charting was found to be inconsistent and staff used verbal and non-verbal methods of pain assessment when non-verbal assessment was required. Outcomes of the pain charting, monitoring and assessment that did occur was variable and gaps were noted in documentation and pain charting, monitoring and reviewing of the effectiveness of pain relief. As a result, the consumer’s experience of pain was not accurately or consistently identified.

The consumer’s representative had advised the consumer could not express pain verbally. Staff acknowledged the Abbey pain scale should have been used to assess the consumer’s pain. Documented personal strategies to manage behaviour did not detail non-pharmacological measures for trial with the potential for pain to be misunderstood as a behavioural issue and for falls to occur.

Strategies to address the consumer’s behaviour were listed as reassure and 1:1 care and other interventions but the interventions were not documented despite a recent review of the consumer by Dementia Support Australia (DSA). Recommendations in progress notes by a physiotherapist for regular checks to be undertaken to prevent falls when the consumer was in particular areas of the service were not included in strategies to address the consumer’s behaviour. Care staff were unaware of triggers for the consumer’s behaviour despite documented episodes of aggression towards others at the service. The consumer’s representative was not aware of any strategies in place to address responsive behaviours. Management responded to the feedback about concerns for monitoring and assessing pain by advising further training would be provided to staff on the use of Abbey pain scale assessments.

In response to the Assessment Team report the Approved Provider supplied clarifying information. The response stated the consumer entered the service only a few weeks prior to the Assessment Contact. The Approved Provider noted the consumer had been identified as having challenging responsive behaviours and was urgently referred to DSA, assessed as possibly having pain and administered pain relief which is why the consumer was assessed as having no pain at the time of the Assessment Contact. The Approved Provider disputes the Assessment Team’s assertion that pain and responsive behaviour may have been be linked and falls prevention was not effectively managed.

At the Assessment Contact on 8 November 2022, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit in relation to Requirement 2 (3)e. The improvements include education for staff in identifying changes in consumer care needs, including identifying deterioration, ensuring daily progress notes are reviewed by a senior clinician and the care manager, ensuring incidents and changes in care needs are identified with appropriate action taken and undertaking regular quality audit reviews of care practice and delivery. Document review and consumer and staff interviews demonstrated care and services are reviewed regularly and following an incident or change to ensure effectiveness. Staff interviewed could identify significant risks for consumers and describe strategies used in alignment with care planning and gave examples of reviews of skin integrity, after consumer behaviour changed and to mitigate weight loss. Care plans are routinely reviewed every 6 months, with reviews of all risk assessments every 12 months, unless there has been incident or identified change, in which case they are done soon after.

Based on the available evidence, I acknowledge the Assessment Team found assessment and planning informed by risks to consumer health was undertaken for most consumers. However, I am not satisfied the service has in place effective assessment and planning systems to ensure risks to the consumer’s health and well-being are considered for all consumers at the service. In making my decision I have considered the significant deficits in assessment of pain and inconsistent strategies to understand and mitigate falls and behaviours and inconsistent assessment and planning for one consumer sampled. I have considered the impact of inconsistent pain assessment and behaviour management identified for the consumer. The impact and significance of these issues has influenced my decision to find Requirement 2(3)(a) Non-Compliant.

Consumer’s current needs, goals and preferences were found to be identified and addressed, and 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. I find Requirement 2 (3)(e) 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Following a Site Audit undertaken 14 to 22 December 2021, the service was found to be Non-Compliant with Standard 3, Requirements (3)(3)(a), (3)(3)(b), (3)(3)(e) and (3)(3)(g). The service did not demonstrate compliance in relation to personal and clinical care being tailored to individual care needs in relation to wound care, pressure area care, and pain monitoring; The service did not demonstrate effective management of risks associated with consumer’s challenging behaviours, falls and weight management and in relation to staff not receiving effective handover information, resulting in an inability to demonstrate understanding of key care needs and risks for consumers. The service did not demonstrate effective strategies to minimise infection-related risks due to failing to comply with effective use of face masks, limited reminder signage and lack of equipment to clean high touchpoint and/or shared equipment.

At the November 2022 Assessment Contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit in relation to Standard 3, Requirements (3)(3)(b), (3)(3)(e) and (3)(3)(g). However, for Standard 3(3)(a) the Assessment Team found the service did not demonstrate use of best practice and tailored care to optimise health and well-being of each consumer in relation to management of changed behaviours, wound documentation and management of pressure injuries, and monitoring following falls.

The Assessment Team found in response to the previous non-compliance, in Requirement 3 (3)a, the service had provided education for staff in skin integrity, pain and restrictive practices. The service had also reviewed the of use of restrictive practices for all consumers and undertakes review of the psychotropic register weekly for accuracy and currency, and reviewed consent for use of restrictive practices. Auditing of wound care and pain management was increased with weekly review of all wounds, audits of clinical care, particularly where there has been identified deficiencies. Reminders to staff were sent through memos, monthly reflections, handover processes and clinical meetings.

However, the Assessment Team found the service was unable to demonstrate provision of best practice and tailored personal and/or clinical care that is safe and effective and optimising health and well-being of each consumer, in relation to management of changed behaviours and use of chemical restraint for one consumer without understanding pain as a trigger. The Assessment Team also raised concerns about and wound documentation and management of pressure injuries for sampled consumers. It found falls management pathways, including neurological observations and management of symptoms, were not applied in line with the service’s policy for one consumer, who experienced 2 falls, failing to demonstrate best practice and using pathways to optimise consumer’s health.

The response from the Approved Provider provided clarifying information. It disputed the findings of the Assessment Team specifically in relation to the named consumer. I have addressed the concerns raised by the Assessment Team for the named consumer under Requirement 2(3)a and have also come to a different view to the Assessment Team about the service’s compliance with this Requirement. On balance I am convinced by the information and explanation in the response provided specifically the lack of impact for the named consumers in regard to pressure area care and neurological observations post falls. I am persuaded that wounds are managed effectively and there is no evidence of adverse outcomes for named consumers in relation to wounds.

In response to the previous non-compliance, for Requirement 3(3)b the Assessment Team found the implemented by the service included education and a skills workshops for clinical and care staff on behaviour management, weight management, and post falls management. Overall review of associated care plans ensures documentation of strategies, and reminders are given for care staff through weekly memos and staff newsletters, with weekly clinical meetings to ensure issues are addressed. Evidence collected through document review and consumer and staff interviews demonstrated the service has effective management of high impact or high prevalence risks associated with the care of each consumer. Sampled consumers admitted for respite had risk assessments identifying key issues, including smoking history, behaviours, mobility, sensorineural needs, skin integrity and nutrition. Care and clinical staff were able to explain key risks for each consumer and management strategies as outlined in the consumer’s care plan. Consumers with identified risk were referred to appropriate specialists for management. A representative was generally positive about improvements to care and the service has a system in place for monitoring new and emerging risks and monitoring them

In response to the previous non-compliance, for Requirement 3(3)e the Assessment Team determined a range of actions were implemented by the service. This included the development of written handover documents, with separation of information for clinical staff and an extract of key needs from the electronic care management system for care staff. Handover documents are kept on file for 4-5 days to ensure changes are communicated to all staff. Auditing of effectiveness of handover, assists with surveys of new clinical staff to determine understanding of key needs and risks for consumers. An agency folder has been developed with key documents, including pathways, logins and contact details. Through document review and consumer and staff interviews the service demonstrated information about the consumer’s condition, needs and preferences is documented and communicated within the organisation and where responsibility for care is shared

Two representatives said they are updated promptly following incidents or changes to care, with one stating the overall communication has greatly improved since the current General Manager commenced at the service early 2022. Staff could describe verbal and written handover processes. The Assessment Team viewed sampled written handovers, noting information in alignment with needs, changes or incidents were recorded.

In response to the previous non-compliance for Requirement 3(3)g the actions implemented by the service included maintaining outbreak folder and COVID-19 Pandemic response Plan with outbreak kits and appropriate levels of Personal Protective Equipment (PPE) with stocktake of PPE done weekly. The Assessment team found staff are regularly reminded and updated about infection protocols through staff meetings and monthly reflection newsletters. The service has dedicated Infection Prevention and Control (IPC) staff and are assisted during an outbreak by the learning business and IPC teams within the organisation to evaluate PPE stations and the correct wearing of PPE. Staff education has been completed in COVID-19 Infection Control and practical assessments in handwashing and donning and doffing.

Based on the available evidence, for Requirement (3)(3)a, I have come to a different view to the Assessment Team. I am satisfied the service has in place systems to ensure each consumer gets care that is best practice, tailored to their needs and optimises their well-being. I was influenced in making my decision by the Assessment Team report and the response from the Approved Provider outlining a lack of evidence of adverse impact for clinical care for any of the named consumers. I have addressed impact for one consumer under Requirement 2(3)a).

I am satisfied the service demonstrates effective management of high impact and high prevalence risks associated with the care of each consumer is in place. 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. The service has implemented effective strategies for the minimisation of infection related risks infection control prevention is in place. Based on the available evidence I find Requirements (3)(3)(b), (3)(3)(e) and (3)(3)(g) Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Following a Site Audit undertaken 14 to 22 December 2021, the service was found to Non-compliant with Standard 6, Requirement 6(3)(c) in relation to lack of response to sampled consumer concerns, with issues being raised several times before actions taken.

At the November 2022 Assessment Contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The Assessment Team found direct oversight and availability is provided to ensure the complaints management process is embedded and actioned in a timely manner, including utilising open disclosure principles to build consumer and representative confidence. Consumers and representatives are encouraged to provide feedback either verbally, in writing or via email and feedback from complainants, indicate satisfaction with the complaint management process. All staff inductions include training about feedback, the complaints process, and open disclosure.

Consumers and representatives expressed satisfaction with the current communication and timely action in response to feedback and/or complaints and indicated the overall tone at the service is more positive and improved. Staff were able to provide examples of open disclosure and assisting consumers to submit feedback and this is reinforced through meeting forums and documentation. The service demonstrated an open and transparent approach in liaising with consumers, representatives and staff when responding to feedback and complaints, and ensuring open disclosure is undertaken if things go wrong.

Based on the available evidence, for Requirement (6)(3)c I am satisfied the service has demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Consumers and representatives are satisfied with the response and timely action in relation to complaints made and communication about and oversight of complaints has improved with a complaint management process in place. I find the service is Compliant with Requirement (6)(3)c.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Following a Site Audit undertaken 14 to 22 December 2021, the service was found Non-compliant in relation to staff not demonstrating sufficient training and understanding in the use of restrictive practices, wound care, behaviour management, falls prevention and management, weight management, and recording clinical documentation.

At the November 2022 Assessment Contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous Site Audit. The improvements include staff education for both clinical and care staff in various care topics and disciplines including behaviour management, weight management, and post falls management. The service has also put in place ongoing review and analysis of trending data from various sources such as feedback and complaints, incidents and clinical indicators to inform training needs.

Consumers and representatives sampled indicated they were comfortable with the abilities of the workforce to deliver care and services. The service has a recruitment and induction process which includes police clearances, visa and qualification checks, as well as buddy shifts.

Staff confirmed the requirement for mandatory and ongoing training monitored for compliance, as well as practical assessment and on the spot checks of competency. Documentation showed a yearly training planner and records of completion. Staff confirmed completion of various training modules via an online platform as well as practical assessments. Management review potential training needs informed by the feedback and complaints, clinical indicators, incident data, staff performance and internal reviews.

Documentation showed staff training for both clinical and care staff in areas such as skin integrity, wounds, falls, weight management, dysphagia, nutrition and hydration, restrictive practices and behavioural management and infection control with upcoming Antimicrobial Stewardship scheduled for November 2022.

Based on the available evidence, for Requirement (7)(3)d I am satisfied the service has demonstrated it has a workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards. Consumers and representatives are satisfied with the skills of the staff in delivering care and services and ongoing training is provided after induction. Training is based on identified needs and monitoring and review by the quality team is in place. I find the service is Compliant with Requirement (7)(3)d.

# 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:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Following a Site Audit undertaken 14 to 22 December 2021, the service was found to non-compliant, in relation to not demonstrating a service-wide clinical governance framework in relation to restrictive practices, including legislative requirements around use of chemical restraint.

At the November 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit. The service has undertaken a review of all care plans for each consumer with changed behaviours reviewed with the assistance from Dementia Support Australia (DSA). The service has completed an organisation wide change of pharmacy to better align with the services requirements for care and services.

Staff education has been completed in restrictive practices and minimising the use of restraint, open disclosure and has upcoming training scheduled for Antimicrobial Stewardship in November 2022.The service engages in the National Antimicrobial Prescribing Survey (NAPS). The service has policies and procedures in place to guide staff practice.

The service has regular weekly meetings at the service level to review clinical practices in conjunction with incident data and clinical indicators with assistance provided by the organisation's quality team. The operational framework is facilitated by reporting undertaken by the General Manager and via Clinical Governance meetings with oversight by the National Quality Director. Education sessions have been provided to staff in restrictive practices and open disclosure with staff confirming participation in training.

The organisation has changed pharmacy to provide more supportive assistance such as, timely reporting on antibiotic usage, attend Medication Advisory Meetings (MAC), liaise with Medical Officers (MO) to improve MO understanding of therapeutic guidelines and to provide staff education. Staff displayed knowledge in minimising the use of antibiotics through non-pharmacological means.

Education in Restrictive Practices has been provided to staff and staff were able to demonstrate knowledge in minimising the use of restraint.

The service demonstrated an open and transparent approach with consumers and representatives and provided examples of open disclosure when things go wrong. A review of the written feedback forms showed examples of apologies made in a timely manner. Staff could describe the principles of open disclosure and confirmed participation in training. Consumers and representatives were complimentary of recent changes confirming things are actioned quickly.

Based on the available evidence, for Requirement (8)(3)e I am satisfied where clinical care is provided the service has a clinical governance framework, including but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure. I find the service is Compliant with Requirement (8)(3)e.

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)