Performance

Report

**1800 951 822**

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| Name of service: | Mercy Place Keon Park |
| Service address: | 15 Tunaley Parade RESERVOIR VIC 3073 |
| Commission ID: | 4329 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 28 March 2023 to 29 March 2023 |
| Performance report date: | 5 May 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 Keon Park (**the service**) has been prepared by N Wapling, 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 20 April 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 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

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)(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 found Non-compliant in Standard 2 in relation to Requirements 2(3)(a) and 2(3)(e) following a Site Audit in March 2022 where it was unable to demonstrate:

* Assessment and planning that consistently identified and considered risks to the consumer’s health and well-being and informed the delivery of safe and effective care and services including in interim care plans.
* Care and services were reviewed when circumstances change or in response to incidents which impact on the needs, goals or preferences of the consumer.

At the March 2023 Assessment Contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service demonstrated it undertakes assessment and planning and processes support the delivery of safe and effective care. Consumers and representatives were satisfied the assessment and care planning process considers risk to the consumer’s health and well-being.

Clinical and care staff demonstrated knowledge of consumers’ risks and described strategies to ensure their safe and effective care. Initial care planning is conducted on admission to the service with the consideration of risk in accordance with the service’s assessment and care planning guidance. Care planning documentation showed care plans had been reviewed and included a range of validated clinical risk assessment tools being completed to identify relevant risks such as pain, skin integrity, behaviour management, nutrition, falls and respite. For consumers subject to chemical restrictive practice the Assessment Team noted some deficits in relation to behaviour support care documentation that were not individualised. In response the Assessment Team feedback during the Assessment Contact, management undertook an immediate review of care planning documents to ensure behaviour care plans are in line with legislative requirements.

The Approved Provider submitted a written response that included clarifying information and supporting evidence. Documentation provided by the approved provider included behaviour care plans of 5 consumers who are subject to chemical restrictive practices recently reviewed and updated. I am satisfied the information provided by the Approved Provider demonstrates behaviour support plans have been reviewed and updated to include individualised strategies for consumers.

The service demonstrated care planning documentation including interim care plans are reviewed in response to incidents or following a change to consumer care and services. Staff demonstrated knowledge in incident management including how they are reported, recorded, and investigate with evidence of consumer, representative and the medical practitioner being informed. Consumer files demonstrated care plans being reviewed after incidents and visiting practitioner and review recommendations were documented. Regular reviews are completed including resident of the day, care plan reviews and consultation with the consumer and representative.

Based on the available evidence, I am satisfied the service has in place effective assessment and planning systems to ensure the consideration of risks to consumers health and well-being are 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 Requirements 2(3)(a) and 2(3)(e) are 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)(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

The service was found Non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b) and 3(3)(g) following a site audit in March 2022 where it was unable to demonstrate:

* Each consumer received clinical care that is tailored to their individual care needs in relation to skin integrity and pressure injuries, pain, and chemical restraint.
* Effective management of high impact or high prevalence risks associated with the care of each consumer such as the risk of falls and weight loss.
* Minimisation of infection related risks such as COVID-19 related infection prevention and control practices.

The service demonstrated tailored care and that best practice principles have been implemented in relation to wound management, skin integrity, pain management and restrictive practices. Representatives interviewed expressed satisfaction with the management of their consumer’s individualised care needs when consultations and discussions occur, and how staff respond in relation to the management of pain, wounds, and restrictive practices. Staff demonstrated their understanding of individual consumer needs providing examples of pain management and non-pharmacological strategies, wound management with preventative strategies for skin integrity, and restrictive practices, particularly environmental and chemical with non-pharmacological strategies. This was consistent with consumer care documentation and the organisation’s policies and procedures. Management have overseen the facilitation of care delivery education, reviewed all consumer’s assessment and care plans and frequent wound management monitoring. Care documentation showed consultations with consumers and /or representatives, assessments, management, monitoring, and evaluation. The Assessment Team observed examples of documentation that were individualised in pain management including pain monitoring, non-pharmacological strategies, and evaluation. Wound management documentation confirmed consistent staging of wounds, management, and evaluations. Restrictive practices confirmed risks, triggers and strategies with informed consent monitoring and reviews by medical practitioners and geriatricians.

The service demonstrated effective management of high impact or high prevalence risks and the effective clinical oversight of safe management. Representatives interviewed were satisfied the service managed these risks and reviewed strategies including post fall management, weight loss and behaviour management. Staff confirmed receiving falls training and demonstrated knowledge of individual consumer’s risks in falls, malnutrition, and behaviours. Documentation included incident reports, assessment, and reviews by specialist practitioners, monitoring and evaluations. Consumer’s experiencing unplanned weight loss were appropriately referred to dietitians for review and care documentation detailed ongoing monitoring and management of risks of malnutrition. Falls documentation included prevention strategies that aligned with staff understanding and input by a multidisciplinary team.

The service demonstrated they minimise infection-related risks and promote principles of antimicrobial stewardship whenever possible. Consumers and representatives expressed satisfaction with staff practices when managing the infection, prevention, and control. Staff confirmed they have received face to face training in infection prevention and control practices. They were able to demonstrate an understanding of antimicrobial stewardship and provided examples. Management had increased observations and monitoring of infection prevention and control practices. Audits demonstrated an increase in compliance of practices. The service has strategies in place to ensure there is an infection prevention and control (ICP) lead available in the service. There is an outbreak management plan that is detailed to provide guidance to staff in the event of infection-related outbreaks. The Assessment Team observed staff wearing appropriate PPE in line with the current guidelines and were also observed cleaning all shared devices and equipment.

Based on the available evidence, I am satisfied the service has in place effective assessment and monitoring systems to ensure the consumers current needs, preferences and risks are effectively monitored and managed. These include personal and clinical care in the management of wounds, skin integrity, pain and restrictive practices, high impact and high prevalence risks in the management of falls strategies and post management occurrence, behaviors, malnutrition, and infection prevention and control practices outbreak, management planning and antimicrobial stewardship. I find Requirements 3(3)(a), 3(3)(b) and 3(3)(g) are compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |

Findings

The service was found Non-compliant in Standard 4 in relation to Requirement 4(3)(c) following a site audit in March 2022 where it was unable to demonstrate:

* The service supported consumers to maintain and participate in social activities that provide a sense of purpose and identity. Consumers were dissatisfied with activities provided and the Assessment Team observed limited interaction and engagement with consumers by staff in communal areas

The service demonstrated consumers are supported to participate in their community, have social and personal relationships and participate in things of interest to them. Consumers and their representatives were satisfied that the consumer is supported to participate in activities of their choice. Staff demonstrated their understanding of individual consumer’s needs and the services introduced to support consumers to participate. The service has introduced initiatives that have engaged consumers, including engaging volunteers and additional lifestyle staff, enhanced engagement in the Memory Support Unit and connected consumers to their community through external organisations. While the service has improved organised activity selection for consumers, they have also implemented alternative activities for consumers to engage in, facilitated by volunteers. Consumer care documentation included information related to the consumers preferred activities and important relationship. Lifestyle documentation confirmed consumer participation in their activities of choice. The Assessment Team observed consumers participating in a range of group activities during the assessment contact.

Based on the available evidence, I am satisfied the service has in place effective supports to enable consumer participation in their community, engage in social and personal relationships and do the things of interest to them. I find Requirement 4(3)(c) is 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

The service was found Non-compliant in Standard 6 in relation to Requirement 6(3)(c) following a site audit in March 2022 where it was unable to demonstrate:

* Appropriate action was taken in response to complaints and an open disclosure process is used when things go wrong.

The service demonstrated that appropriate action is taken in response to complaints and open disclosure is used when things go wrong. Consumers and representatives were satisfied issues they have raised with staff or management were resolved within a reasonable timeframe to their satisfaction. Management described open disclosure principles in their handling of feedback and complaints. Most staff were familiar with the term open disclosure, they were able to explain how they inform and apologise to consumers and representatives when things go wrong. Documentation demonstrated complaints received in the last 6 months have been resolved in a timely manner.

Based on the available evidence, I am satisfied the service has in place an effective system to respond to feedback and complaints, and practice open disclosure when things go wrong. I find Requirement 6(3)(c) is compliant.

# Standard 7

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| 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

The service was found Non-compliant in Standard 7 in relation to Requirement 7(3)(a) following a site audit in March 2022 where it was unable to demonstrate:

* The workforce is planned to enable the delivery and management of safe and quality care and services.

The service demonstrated that staffing levels enable staff to deliver the care needs of consumers. Most consumers and representatives interviewed were satisfied there are enough staff available to assist them in a timely manner. Staff from different roles described their satisfaction with the staffing levels and explained how shifts are effectively managed when staff go on planned or unplanned leave. Management described strategies implemented to manage staffing challenges. For example, increased recruitment of staff across various professions to fill the rosters, monitoring of call bell responses and investigates and actions when there has been an increased in response time. The Assessment Team reviewed staff rosters and observed unplanned leave was replaced on all occasions in a 4-week period. The Assessment Team observed staff responding to call bells and consumer requests in a timely manner.

Based on the available evidence, I am satisfied the service has in place effective practices to enable appropriate plan staffing level to attend to consumer care needs. I find Requirement 7(3)(a) is compliant.

# 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

The service was found Non-compliant in Standard 8 in relation to Requirement 8(3)(e) following a site audit in March 2022 where it was unable to demonstrate:

* Appropriate management of restrictive practices being identified by the organisation governance processes.

The service demonstrated an effective clinical governance framework is in place supported by policies and procedures relating to antimicrobial stewardship, minimising restraint, and open disclosure. The psychotropic register has been reviewed to ensure it is complete and current, authorisation and information consent has been obtained and documented, staff have completed education in chemical restraint and restrictive practices procedures. Staff demonstrated knowledge and application of minimising restrictive practices, infection control and antimicrobial stewardship, and open disclosure. Management described and provided evidence of the oversight of the clinical governance framework. For example, audit results, staff education records, restrictive practices procedures and electronic records. The service was updating their restrictive practices procedure and documentation, consumer documentation demonstrated that behaviour support plans are developed for consumers subject to restrictive practices and were being updated. The service provided evidence of reviewed and updated care plans after the assessment contact in response the Assessment Team report which I have considered in making this decision.

Based on the available evidence, I am satisfied the service has in place an effective clinical governance framework to manage the legislative requirement of minimising restrictive practices, antimicrobial stewardship, and open disclosure. I find Requirement 8(3)(e) is compliant.

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)