Performance

Report

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| Name of service: | Mercy Place Montrose |
| Service address: | 991 Mount Dandenong Tourist Road MONTROSE VIC 3765 |
| Commission ID: | 4477 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 25 July 2023 to 26 July 2023 |
| Performance report date: | 24 August 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 Montrose (**the service**) has been prepared by C Spiller, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 August 2023

# Assessment summary

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| 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 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

Requirements 2(3)(a) and 2(3) were found non-compliant following a Site Audit from 6 June 2022 to 9 June 2022. The service did not demonstrate:

* Care planning documents consistently provide comprehensive assessment and individualised care planning in relation to consumers’ health and well-being risks, specifically regarding behaviour, medication, falls management and specialised care needs.
* Care and services were reviewed regularly for effectiveness for consumers demonstrating challenging behaviour and when incidents impact the needs, goals, or preferences of the consumer. Not all consumers had received effective reviews of their care plans following incidents.

The organisation has implemented several actions in response to the non-compliance identified at the Site Audit 6 June 2022 to 9 June 2022 including, but not limited to;

* Quality staff and ‘roving care managers’ reviewing all assessments and care plans for each consumer, to ensure currency, completeness, accuracy and congruency.
* Education was provided for clinical staff in relation to updating assessments and care planning.
* Daily review of progress notes is undertaken to identify incidents and changes in condition and ensure the required action is taken plans and the triggers for doing so.
* The medication management system was reviewed to identify gaps and deficiencies, and a new medication system introduced.
* A daily review of consumers’ progress notes is conducted by the clinical care manager and the most senior registered nurse, to ensure appropriate follow-up.
* A care handover report is printed daily and distributed to each house to ensure staff access to readily available information to deliver individualised and safe care to the consumers

During the Assessment Contact conducted 25 July 2023 to 26 July 2023, in relation to Requirement 2(3)(a) the service demonstrated assessment and planning considers risk to consumers’ health and well-being and informs the delivery of safe and effective care. All sampled representatives expressed confidence in the care planning process and described partnership informing safe and effective care for their consumer. Clinical and care staff demonstrated knowledge of how they provide safe and effective care for each individual consumer. All staff interviewed confirmed they have completed training provided by the service and could apply it to consumers’ delivery of care. Care planning documents reflect the outcomes of validated risk assessments in relation to responsive behaviours, medication, falls and specialised care needs.

In relation to Requirement 2(3)(e), the service demonstrated it has improved the way it reviews the effectiveness of consumer care and services. All sampled consumers and representatives interviewed said the consumers’ care and services are regularly reviewed for effectiveness and as the need arises, and staff are knowledgeable about their needs, preference, and goals of care. Overall, clinical documentation for the sampled consumers evidenced that care plans are reviewed and updated 6-monthly in accordance with the service’s policy, and if changes occur.

Accordingly, taking into consideration to the information available to me, I find the Service is now compliant with Requirements 2(3)(a) 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. | 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 |

Findings

Requirements 3(3)(a) 3(3)(b) and 3(3)(e) were found non-compliant following a Site Audit conducted 6 June 2022 to 9 June 2022.

* The service did not demonstrate it provided safe, effective and tailored care to consumers subject to restrictive practices. The psychotropic register did not show all consumers prescribed psychotropic medication and chemical restraints were not listed on the register.
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* Assessments and care plans did not always contain sufficient information to guide staff in relation to relevant consumer care needs such as responsive behaviours and complex catheter needs. The service did not have a handover process for effective sharing of information where care is shared.

The organisation has implemented several actions in response to the non-compliance identified at the Site Audit 6 June 2022 to 9 June 2022. These actions include, but are not limited to;

* Missing restrictive practice assessments, authorisations and consents were completed and/or obtained.
* Staff education in relation to restrictive practice and psychotropic register requirements.
* Restrictive practice education has been provided to staff more broadly. Education regarding restrictive practice has also been added to the service’s new orientation package.
* Education was provided to staff on managing changed behaviours, including identifying triggers and appropriate strategies, behaviour charting, recording information within the behaviour care plan, and creating an incident report where required.
* The medication management system was reviewed to identify gaps and deficiencies, and a new medication system introduced.
* Assessments and care plans were reviewed for each consumer, to ensure currency, completeness, accuracy, and congruency.
* The handover process was reviewed and changed.
* The consumers’ care plan evaluation and review timeframe was changed from three monthly to six monthly in August 2022.

During the Assessment Contact 25 July 2023 to 26 July 2023, in relation to Requirement 3(3)(a) the service demonstrated the provision of safe, effective care to consumers subject to restrictive practices. All sampled representatives interviewed were satisfied consumers receive clinical care that is right for them. Clinical staff described how they know clinical care is best practice. Consumer files sampled included assessment and care plans, progress notes and charting. These overall reflected tailored care and best practice principles being implemented. Management discussed and demonstrated training delivered in response to the non-compliance. Staff described training in relation to restrictive practice and said they can easily access online education. The organisation has procedures and guides relating to best practice principles in relation to restrictive practices, psychotropic medication and chemical restraints.

In relation to Requirement 3(3)(b), the service demonstrated effective management and clinical oversight of high impact and high prevalence risks associated with consumers’ care, in relation to behaviour, medication, falls and complex catheter management. Representatives were satisfied the service is effectively managing risks to consumers. Staff and management described high impact high prevalence risks for consumers at the service. Management discussed how high impact high prevalence risks are effectively managed through clinical data monitoring, trending and risk mitigation strategies for individual consumers. Care documentation identified individual consumers’ high impact high prevalence risks. The organisation has procedures and guides relating to best practice principles specifically behaviour, medication and falls management.

In relation to Requirement 3(3)(e), all sampled consumers and representatives said they were confident staff were knowledgeable about consumers’ current needs and preferences and communicated these with other health professionals as appropriate. A comprehensive and consumer’s individualised handover copy was observed available in each house at the service. Allied health, clinical and care staff interviewed, explained collaboration between nursing staff, allied health professionals, and medical practitioners supported continuity of care for consumers. Consumers’ progress notes are reviewed daily to ensure care interventions are captured and follow-up actioned.

Accordingly, with the information available to me, I find the service is now compliant with Requirement 3(3)(a), 3(3)(b) and 3(3)(e).

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| 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

Requirements 4(3)(a) and 4(3)(c) were found non-compliant following a Site Audit conducted 6 June 2022 to 9 June 2022.

The Assessment Team found the service did not provide activities that met all care recipients’ goals, needs or preferences to optimise their independence, health, well-being and quality of life. Care recipients reported activities were inadequate and there were not enough staff available to provide support to all consumers in order to fully participate.

Consumers reported they were dissatisfied with the activities on offer. The Assessment Team observed consumers seated in the communal lounge not engaged in activities on most days of the Site Audit. Consumers with dementia were observed to have escalating changed behaviours in the afternoon with no interaction or structured program available.

The service has implemented several actions in response to the non-compliance identified at the Site Audit from 6 June 2022 to 9 June 2022. Improvement action have included;

* Increased staffing of care workers for the morning shift, who provide daily one-on-one time with consumers in their ‘house’.
* The lifestyle team have provided activities boxes to each of the ‘houses’ to use with consumers.
* Lifestyle staff have arranged for regular visits of children from the local kindergarten and a fortnightly concert.

During the Assessment Contact on 25 July and 26 July 2023, consumers overall expressed satisfaction with the effectiveness of the services and supports for daily living that meet their needs, goals and preferences. Lifestyle and care staff discussed the activities they undertake with consumers. The Assessment Team observed consumers engaged in a variety of activities in their ‘houses’ and in the group led activities. Care planning documentation was current and recorded consumer preferences. Consumer participation in activities, including one-on-one time, was recorded in progress notes. Consumers living with dementia were observed engaging in activity aligned with their management plans.

Accordingly, with the information available to me, I find the service is now compliant with Requirement 4(3)(a) and 4(3)(c).

# 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 |
| 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

Requirements 8(3)(d) and 8(3)(e) were found non-compliant following a Site Audit conducted 6 June 2022 to 9 June 2022. The service’s incident management system and risk management framework were found to not be effective in the management of 2 consumers with changed behaviours. Behaviour incidents recorded in progress notes had not been identified as reportable incidents, nor feedback from consumers actioned with incident reports on alleged wandering behaviour. For one consumer with increasing changed behaviours, there did not appear to have been adequate action taken in relation to the risk presented. The Assessment Team found the service did not consistently document reviews of consumers in consultation with their medical officer and restrictive practice substitute decision maker where appropriate.

The service has implemented several actions in response to the non-compliance identified at the Site Audit 6 to 9 June 2022 which have been effective. These actions include;

* A daily review of progress notes is conducted to ensure appropriate follow-up.
* Staff were reminded of their responsibility to ensure all incidents are recorded in progress notes in a timely manner.
* Information on incident reporting was added to the service’s induction program, which has been extended from around an hour to almost a full day.
* Missing restrictive practice assessments, authorisations and consents were completed and obtained.
* Staff education on psychotropic register requirements.
* Education was provided to staff in relation to restrictive practice and was added to the service’s new orientation package.

During the Assessment Contact conducted 25 July 2023 to 26 July 2023, in relation to Requirement 8(3)(d) the service demonstrated incidents are reported by staff and are generally investigated, and that staff are aware of their responsibility to ensure incidents are reported. Management and quality staff outlined the service’s incident management system. All staff interviewed demonstrated an understanding of what constitutes an incident, including allegations of abuse or neglect, and their reporting responsibilities. Overall, consumer representatives expressed satisfaction with the management of incidents involving their family members. Review of incident management documentation showed appropriate follow-up of consumers at the individual level following incidents but did not always evidence thorough investigation of incidents or demonstrate actions taken. Review of clinical files and the service’s Serious Incident Response Scheme (SIRS) records showed reportable incidents are reliably reported to the Aged Care Quality and Safety Commission, and allegations of rough handling or abuse are thoroughly investigated and managed by the service. Review of quality meeting minutes evidenced review of incidents and trends, and of actions taken by the service in response. The response submitted by the provider, stated that documentation of investigation outcomes and actions has been strengthened and a new incident reporting system is being implemented later in 2023, which will strengthen further.

In relation to Requirement 8(3)(e), management confirmed the psychotropic register is reviewed weekly by the clinical manager. The register was found however to contain some inaccuracies in relation to chemical restraint. In response to the Assessment Team’s feedback in relation to the psychotropic register and legislative deficits, management acknowledged the deficits across the psychotropic register and care planning documentation. In response they immediately reviewed all consumers prescribed psychotropic medication, accurately identified those considered chemical restrictive practice, and commenced undertaking a comprehensive review to include behaviour support in accordance with legislative requirements. Despite these issues consumers sampled who are subject to restrictive practice were found to have authorisations, behaviour care plans, behaviour charting, and behaviour and risk assessments in place. Regular reviews were evidenced in clinical documentation. All interviewed clinical and care staff demonstrated an understanding of restrictive practice consistent with their roles, and their related responsibilities. Staff said chemical restraint is used as a last resort.

Accordingly, with the information available to me, I find the service is compliant with Requirements 8(3)(d) and 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-2)