Performance

Report

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| Name: | MiCare Overbeek Lodge |
| Commission ID: | 3188 |
| Address: | 736 Mount Dandenong Road, KILSYTH, Victoria, 3137 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 28 May 2024 to 29 May 2024 |
| Performance report date: | 28 June 2024 |
| Service included in this assessment: | Provider: 818 MiCare Ltd  Service: 1947 MiCare Overbeek Lodge |

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 MiCare Overbeek Lodge (**the service**) has been prepared by Danielle Utting, 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 (performance assessment) – 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 25 June 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **Not Applicable as not all Requirements Assessed** |
| **Standard 8** Organisational governance | **Not 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 3**

* Requirement 3(3)(a) – the approved provider ensures each consumer gets safe and effective personal and clinical care including in the areas of restrictive practices, behaviour support and wound management.
* Requirement 3(3)(b) – the approved provider ensures effective management of high-impact or high prevalence risks, including the identification, monitoring, management, and evaluation of risks for individual consumers who experience falls and responsive behaviours.
* Requirement 3(3(d) ensure that the service identifies changes or deterioration in the health of consumers and responds in a timely way.

**Standard 8**

* Requirement 8(3)(d) effective risk management systems and practices to ensure the management of high impact or high prevalence risks for consumers.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |

Findings

I am satisfied with the Assessment Team recommendations and find the service not compliant in Requirements 3(3)(a), 3(3)(b) and 3(3)(d).

In relation to 3(3)(a), while consumers and representatives were satisfied consumers’ care needs and preferences are being met, the service did not demonstrate that each consumer receives clinical care that is effective, safe, and optimises their health and well-being. The service did not consistently identify consumers subject to environmental restrictive practices, and as a result, complete assessment and behaviour support planning. Updated consent authorisations for restrictive practices was not always obtained. Behaviour support plans (BSP’s) reviewed did not document individualised and tailored strategies and interventions. The service did not consistently consider or investigate factors contributing to consumers’ changed behaviours and did not consistently plan interventions to minimise escalation. Staff did not have access to up to date policies for restrictive practices and were not able to describe the tailored strategies they use to support consumers with changed behaviours. Care documentation did not evidence staff trialling and evaluating non-pharmacological strategies prior to administration of as required psychotropic medication. When as required psychotropic medications was administered there was no evidence of evaluation to determine the effectiveness.

Pressure injury risk assessment, ongoing wound assessment, and clinical care were not regularly monitored and reviewed for effectiveness. Pressure injury risk was incorrectly assessed impacting on the implementation of effective prevention and mitigation strategies. The service did not demonstrate effective pain management, with evidence of inconsistent assessment and documentation. Care documentation did not demonstrate effective individualised pain interventions reflective of consumer needs and preferences. The service’s restrictive practices policy to guide staff practice was not current and did not reflect current legislative requirements.

In relation to 3(3)(b), the service did not demonstrate that risks related to falls, skin break down and pressure injuries was identified and managed. Consumer risk assessments did not evidence accurate information, and care plans were not always updated to reflect current information, impacting on the safe delivery of care to consumers. Staff demonstrated knowledge and understanding regarding high-impact and high-prevalence risks for consumers related to falls, changed behaviours and pressure injuries, and strategies to mitigate risk. The service demonstrated the effective management of catheters and oxygen.

In relation to 3(3)(d), the service was unable to demonstrate recognition and response to consumers’ changing health needs. Not all documentation reviewed included identification, escalation, and reporting of consumers’ health deterioration. Consumer risk assessments related to skin integrity and restrictive practices were inaccurately completed resulting in incorrect risk scores, impacting on timely identification of changes resulting deterioration in consumers’ health.

The Approved Provider submitted a response (the response) and Plan for Continuous Improvement (PCI). The response detailed the corrective actions planned and completed. The response outlined challenges the service has faced in maintaining a consistent workforce. The use of agency and contract workforce is noted by the service as a contributing factor to the errors and inaccuracies in the assessment, planning and delivery of care for consumers identified by the Assessment Team. While I consider the service’s recent improvements to recruitment and reduction in the use of agency staff will support the timely and accurate completion of documentation, the upskilling of staff will take time to implement and embed into practice.

The service has completed improvement actions which include comprehensive care plan reviews for high risk consumers and completion of root cause analysis of consumers the Assessment Team had identified with impact to care. Staff training and education in topics such as wound and pain management, implementation of a monitoring deterioration tool, review of restrictive practices processes and introducing oversight mechanisms to ensure staff are accurately completing validated assessment tools and charting was also undertaken.

While I acknowledge the actions taken by the service since the Assessment Contact, further time is required to ensure improvements continue to be implemented in practice. I am not satisfied the service has had sufficient time to demonstrate the systems in place are effective to ensure each consumer receives tailored care that is best practice, ensures they are managing high-impact and high-prevalence risks including changed behaviour and wound management, and ensures the timely recognition and response to deterioration or changes in a consumer’s health. As a result, and with consideration to the available information, I find these requirements are not 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

With consideration to the available information, I agree with the Assessment Team recommendations and find the service compliant with Requirement 7(3)(a).

The service demonstrated the workforce is planned to deliver care and services to consumers. Consumers and representatives were satisfied with the number of staff available to care for consumers. A review of roster documentation evidenced the use of casual staff to fill vacant shifts. The service has a registered nurse rostered 24 hours per day. Staff were satisfied there are sufficient staff to enable them to complete their work tasks and that the service ensures shift vacancies are covered by casual staff. Management explained the system for review of call bell reports and the expectations for staff to respond to call bells within 10 minutes.

# 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. | Not Compliant |

Findings

I am satisfied with the Assessment Team recommendations and find the service not compliant in Requirements 8(3)(d).

The service was unable to demonstrate an effective risk management system in place for high-impact or high-prevalence risks, identification and response to abuse and neglect of consumers, and management and prevention of incidents. The Assessment Team review of documentation evidenced inaccurate assessment of risk for some consumers. While the service had in place a process for analysis of incidents, this was not consistently completed, resulting in missed opportunities to further mitigate risks and tailor strategies for consumers.

The Approved Provider submitted a response (the response) and Plan for Continuous Improvement (PCI). The response detailed the corrective actions planned and completed. The response included details of completed analysis of incidents for consumers and subsequent learnings. The response also provided information about the creation of a new role to oversee the delivery of best practice care and management of clinical care risks. A management workshop was held in May 2024 with a focus on enhancements to systems and processes and alignment of practices with the future implementation of the Strengthened Standards. The services response included current policies such as restrictive practice, wound care policy and deterioration recognition and response process.

The response and PCI submitted by the Approved Provider includes evidence of implemented actions and future commitment to ensuring improvement in current practice. While I acknowledge the actions taken by the service since the Assessment Contact, further time is required to establish the new clinical oversight role and embed and evaluate the process improvements. I am not satisfied the service has in place effective risk management systems and practices. As a result, and with consideration to the available information, I find this requirement 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-2)