Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | MiCare Overbeek Lodge |
| Commission ID: | 3188 |
| Address: | 736 Mount Dandenong Road, KILSYTH, Victoria, 3137 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 9 September 2024 to 10 September 2024 |
| Performance report date: | 15 October 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 M Murray, 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 (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 26 September 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements were 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.

* Ensure all consumers, including consumers receiving respite care, have their clinical needs assessed effectively and that the consumer’s immediate clinical care needs are established as part of this assessment process.
* Ensure validated clinical assessment tools are utilised and that a suitably qualified staff member undertakes the required assessments.
* Support staff to understand their accountabilities for undertaking effective clinical and other health assessments.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | | Not Compliant |
| 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service does not comply with Requirement 2(3)(a) and as a result does not comply with Standard 2.

The Assessment Team reported that assessment and planning does not adequately consider risks relevant to each consumer’s health and wellbeing.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Staff are not completing assessment and care planning in a way that informs effective clinical care. Clinical assessments for consumers entering the service, including those receiving short term respite care are not completed in a reasonable time. A review of care documentation sampled by the Assessment Team noted four out of five consumer’s assessments did not fully capture relevant clinical risks or were not completed in line with the consumer’s immediate care needs.

Examples of immediate clinical risks that had a delayed assessment include tracheostomy management, a delay of four weeks from entry to the service, catheter management, a delay of ten days from entry to the service and an ongoing risk of an adverse medication outcome.

The Assessment Team discussed the care needs of the consumers sampled with clinical staff who did not demonstrate an awareness of their responsibility to effectively assess risks for consumers receiving care. In discussions, clinical staff said one consumer is self-managing their clinical needs, for another they rely on the consumer to self-report if they take ‘as required’ psychotropic medication in addition to regular anti-depressant medication.

The approved provider’s response to the Assessment Team’s report acknowledges room for improvement in Requirement 2(3)(a). The response also points to other evidence in Standard 3, which in their view demonstrates that the service’s overall approach to care planning is robust.

A number of actions already undertaken are outlined in the approved provider’s response, including:

* A review of the service’s admissions checklist for both respite and permanent admissions to ensure a thorough and timely review of the complex care needs of consumers occurs from the outset.
* A review of the care manager’s checklist to increase oversight of the assessment process for consumers entering the service.
* The establishment of a clinical safety and best practice team. The completion of comprehensive assessments and care plan reviews for high-risk consumers.

I do not agree with the approved provider’s position that the Assessment Team’s evidence throughout the report in Standard 3 is supportive of a finding of compliance in Standard 2(3)(a). In my view, Requirement 2(3)(a) requires clinical staff use validated clinical assessment tools to establish each consumer’s immediate clinical care needs on entry to the service. I am satisfied that this has not occurred for the consumers reviewed by the Assessment Team.

I note that the purpose of this assessment of performance was to assess whether the service had returned to full compliance with the Aged Care Quality Standards following a decision in June 2024 that the service had failed to comply with Standard 3 and Standard 8.

While I acknowledge the proactive approach of the approved provider in responding to the information contained in the Assessment Team’s report, I am not satisfied, given the service’s own oversight systems did not identify the deficit in the assessment of new consumers, that the service has the capacity to embed any new practices without further oversight by the Aged Care Quality and Safety Commission.

Based on the evidence summarised above, I find the provider, in relation to the service, non-compliant with Standard 2 Requirement (3)(a).

# 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. | 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)(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. | Compliant |

Findings

Requirement 3(3)(a)

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service complies with Requirement 3(3)(a).

The Assessment Team provided evidence, summarised below, relevant to my finding.

The service was found non-compliant with this Requirement following an Assessment Contact conducted from 28 May 2024 to 29 May 2024. At that time the service did not demonstrate effective care in relation to consumers’ pain, the use of restraint and/or the management of wounds.

Since the finding of non-compliance the service has implemented a number of actions as summarised below.

* Physiotherapist assessment of consumers’ experiencing pain and updates to pain care plans.
* Development of behaviour support plans with geriatrician input as required.
* Training for staff in pressure injury prevention, wound management, pain management, and restrictive practices.

During the Assessment Contact conducted from 9 September 2024 to 10 September 2024, consumers and representatives said they are satisfied that consumers’ pain is being managed, general practitioners have discussed the use of chemical restraint, wounds are dressed regularly, and pressure care is being undertaken.

Staff outlined how they effectively monitor consumers for signs of pain including prior to clinical procedures and report when pain is identified. Staff also discussed how they regularly reposition of consumers at risk of pressure areas and report any breakdown in a consumer’s skin integrity.

Consumer care documentation supported that wounds are effectively managed. Wound management plans reflected input from a general practitioner or a wound nurse consultant. Wounds are regularly reviewed, with measurements and wound photography completed by a registered nurse weekly.

Consumers subject to restrictive practice have a behaviour support plan which is regularly reviewed and updated, and records are individualised with non-pharmacological strategies and interventions. Informed consent is obtained every 3 months.

The Assessment Team’s report provides sufficient evidence that the service’s clinical management of pain, wounds, pressure area prevention and chemical restraint reflect a best practice approach.

Requirement 3(3)(b)

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service complies with Requirement 3(3)(b).

The Assessment Team provided evidence, summarised below, relevant to my finding.

The service was found non-compliant with this Requirement in June 2024 as it did not demonstrate effective management of consumers’ risks of falls, skin integrity and wounds.

Since the finding of non-compliance, the service has implemented improvement actions which have been effective. These include reviewing falls management and skin integrity protocols, providing education and training to staff on high-impact and high-prevalence risks and education on wound management led by a wound consultant.

During the Assessment Contact conducted from 9 September 2024 to 10 September 2024, there was evidence of staff effectively managing high-impact and high-prevalence risks associated with consumer care.

Consumers and representatives were satisfied with the service’s management of falls. The Assessment Team’s report outlines that staff adhere to the service’s falls management guidelines and appropriate falls prevention measures are implemented. Post-fall interventions include registered nurse assessment, neurological observations, pain assessments, physiotherapist and/or general practitioner review, and clinical review of the incident.

Wound management at the service is effective. Staff seek input from general practitioners and/or a wound consultant as appropriate.

Each consumer’s weight is regularly monitored and any consumer with continuing or significant weight loss is referred to their general practitioner and a dietitian. Staff described various interventions and strategies for at-risk consumers, such as verbal encouragement and the use of nutritional supplements.

The Assessment Team’s report provides sufficient evidence that the service is managing consumer risks which are prevalent in the service and managing any individual risk that would have a detrimental impact on a consumer if the risk was to occur.

Requirement 3(3)(d)

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service complies with Requirement 3(3)(d).

The Assessment Team provided evidence, summarised below, relevant to my finding.

The service was found not compliant with this Requirement following an Assessment Contact conducted from 28 may 2024 to 29 May 2024, as it did not demonstrate a timely response to consumer deterioration.

Since the finding of non-compliance, the service has implemented improvement actions which have been effective. These include providing training across a range of clinical areas; implementing training in root cause analysis to identify gaps in staff practice; and the implementation of a new monitoring protocol to enhance the ability of staff to manage deterioration.

During the Assessment Contact conducted from 9 September 2024 to 10 September 2024, the service demonstrated changes in consumer condition are recognised, reported, and responded to in a timely manner.

Staff described how they report any changes in the consumers and where an incident occurs, prompt actions to alert the clinical staff and provide care as required. Clinical staff provided examples of immediate care and monitoring where a change in consumers’ health had been recognised.

Consumer care documentation reflected the incidents or deterioration were acted on in a timely manner, with appropriate assessment, care provision and where required, transfer to hospital for further medical investigation and treatment.

The service has a documented deterioration recognition and response process.

The Assessment Team report provides sufficient evidence that the service has a coordinated approach to recognising when a consumer’s health or wellbeing is deteriorating, and that appropriate clinical assessment occurs, and appropriate action is taken.

# Standard 8

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

Findings

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service complies with Requirement 8(3)(d).

The Assessment Team provided evidence, summarised below, relevant to my finding.

The service was found not compliant with this Requirement following an Assessment Contact conducted 28 May 2024 to 29 May 2024. It did not demonstrate risk management systems effectively supported the management of high-impact and high-prevalence risks, identification of and response to abuse and neglect, or management and prevention of incidents.

Since the finding of non-compliance, the service has implemented improvement actions which have been effective. These include the provision of training in areas of clinical care and monitoring of training completion by management; the provision of training in root cause analysis to identify gaps in staff practice; the creation of a care manager daily checklist to ensure comprehensive monitoring and escalation of risks and deterioration; and the recruitment of a clinical safety and best practice manager, and a clinical support coordinator, to enable oversight of clinical care and support best practice.

During the Assessment Contact conducted from 9 September 2024 to 10 September 2024, the service demonstrated effective risk management and practices. Consumers and representatives were satisfied the service responds promptly to incidents or concerns regarding abuse or neglect, and balances risks with consumer quality of life. Staff work to reduce risks to consumer health and well-being while upholding consumers’ rights to choose the care they receive. Staff understand their reporting requirements in relation to serious incidents, having received training in the Serious Incident Response Scheme (SIRS). This was supported by the service’s SIRS register which demonstrated appropriate reporting. There was evidence that root cause analysis of medication incidents and the ensuing education to staff had led to a reduction in such incidents.

Risks including falls, unplanned weight loss, and pressure injuries are identified, monitored and reviewed. The Assessment Team report reflected a decrease in such incidents during the period July 2024 to August 2024, correlating with the implementation of effective management strategies.

Progress notes and incidents are reviewed daily by nursing staff and the care manager, to ensure concerns and incidents are actioned in a timely manner. Incidents are used as opportunities to improve care and services, triggering staff education.

The Assessment Team report provides sufficient evidence that the governing body has the information available to it to effectively manage risk across the service.

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)