Performance

Report

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| Name: | Mosman Park Nursing Home |
| Commission ID: | 7849 |
| Address: | 57 Palmerston Street, MOSMAN PARK, Western Australia, 6012 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 21 November 2023 |
| Performance report date: | 5 January 2024 |
| Service included in this assessment: | Provider: 934 Fresh Fields Aged Care Pty Ltd  Service: 4860 Mosman Park Nursing Home |

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 Mosman Park Nursing Home (**the service**) has been prepared by A. Kasyan, 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 15 December 2023 and
* the performance report for the Site Audit conducted from 20 June 2023 to 22 June 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Compliant |

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 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The service was found non-compliant in this requirement following a Site Audit conducted from 20 to 22 June 2023, where the assessment team found the service did not apply best practice principles in relation to the risks associated with the minimisation of restrictive practice, specifically chemical restraint.

At the assessment contact visit in November 2023, the assessment team found the service has made a number of improvements to address the non-compliance including staff training and a review of psychotropic medications for the previously identified consumers subject to chemical restraint to align the provision of care with legislative requirements.

The assessment team found the service demonstrated effective management of high-impact or high-prevalent risks associated with the management of falls, unplanned weight loss and pressure injuries. However, deficits in the management of risks associated with the use of chemical restrictive practices remain.

A review of a sampled consumer’s file showed, when a new psychotropic medication, Pro Re Nata (PRN or as required), was prescribed for agitation, the service did not identify the medication as being a chemical restraint and did not update the consumer’s care plan and behaviour management plan as required by legislation. Behaviour management plan did not provide clear directions to staff on how to use this medication and other non-pharmacological strategies to effectively manage the consumer’s changed behaviours. Whilst staff were using non-pharmacological strategies, these were ineffective and despite this, staff continued using them.

PRN medication was never used, and at the time of the assessment contact, the consumer’s agitation had subsided as staff advised they had effectively addressed triggers, such as pain and insomnia. However, PRN psychotropic medication remained prescribed and available for use. The consumer’s behaviour management plan did not identify effective non-pharmacological strategies for use in the future, in the event the consumer’s behaviours again escalate, leading to the possibility of inappropriate use of the chemical restraint.

The provider responded by stating that PRN medication is a treating agent for a consumer’s long term mental health illness and both the clinical management team and the consumer’s treating general practitioner do not believe this medication should be classified as a chemical restraint. The provider confirms the assessment team’s finding that whilst PRN medication is available to manage agitation, this not been administered and is prescribed for use in the event of a re-exacerbation of the mental health illness symptoms.

The response provides evidence, such as progress notes, to demonstrate implementation of both pharmacological and non-pharmacological interventions and evaluations of its effectiveness, including in relation to identified triggers, such as disturbed sleep patterns and pain.

After reviewing the evidence and information presented in the assessment team’s report and the provider’s response, I find requirement 3(3)(b) compliant. Whilst the assessment team found ineffective systems and process for managing risks associated with the use of chemical restraint and management of changed behaviours, the provider’s response and supporting evidence demonstrated processes and staff practices ensure the risk is as low as possible.

Whilst the assessment team found the PRN medication should have been identified as a chemical restraint, the provider’s response demonstrated the prescribing was done within the context of treatment plan that includes regular, scheduled doses of the same medication to address symptoms of the mental health illness and the intent behind the prescription was not to control the consumer’s behaviour but rather to address symptoms associated with the diagnosed disorder.

The provider acknowledges the assessment team’s finding regarding limited guidance in the consumer’s care plan regarding the circumstances in which the PRN medication might be administered and I encourage them to review their processes to ensure rationale for medication prescriptions are carefully documented and known to staff.

In relation to management of the risks associated with the consumer’s changed behaviours, I find these were managed effectively which is evidenced through reduction in behaviours and the consumer’s improved well-being, referrals to specialised services, regular monitoring, addressing triggers, comprehensive approach to managing mental health relapse symptoms and involving the consumer and their representative in decision-making.

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)