

**Performance Report**

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| Name: | Mutkin Residential Aged Care |
| Commission ID: | 5239 |
| Address: | 87 Back Beach Road, YARRABAH, Queensland, 4871 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 9 October 2024 to 10 October 2024 |
| Performance report date: | 14 November 2024 |
| Service included in this assessment: | Provider: 5706 Mutkin Residential and Community Care Indigenous Corporation  Service: 3596 Mutkin Residential Aged Care |

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 Mutkin Residential Aged Care (**the service**) has been prepared by Micheal Cooper, 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, older people/representatives and others
* the provider’s response to the assessment team’s report received 6 November 2024

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not Compliant** |
| **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.

* In relation to Requirement 3(3)(a), the approved provider must implement processes to ensure care provided is safe and best practice, particularly in relation to the implementation, monitoring, and review of consumers who are subject to an environmental restrictive practice.
* In relation to Requirement 7(3)(d), the approved provider must implement processes to ensure the workforce is trained and equipped to work and achieve positive outcomes under the Quality Standards. This also includes a monitoring process to ensure the workforce remains up to date with improved guidance and material that is relevant to their job roles.
* In relation to Requirement 8(3)(c), the approved provider must implement processes to ensure staff have access to relevant information to inform areas of improvement including the analysis of data, complaints, and feedback. The approved provider must implement processes to monitor financial income, expenditure, and revenue to ensure the service remains viable and funds are allocated and maintained to ensure appropriate resources and equipment are available to meet the needs of 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 |

Findings

The assessment contact reports consumers and representatives were satisfied with the care and services consumers receive. Care documentation and interviews with staff and management evidenced the service is safely managing consumers’ care needs in relation to chemical restrictive practice, pain management, wound care management and personal care.

The assessment contact reports consumers are subject to environmental restrictive practice without appropriate assessment, planning, and authorisation in place. Service documentation evidenced the services restrictive practice policy had not been reviewed since August 2023. Staff did not demonstrate an understanding of environmental restrictive practice including the required assessments and ongoing review processes involved when implementing an environmental restrictive practice.

In response to the deficiencies identified, the approved provider outlined actions the service plans to take to remediate the deficiencies identified including:

* Education will be provided to all staff in relation to restrictive practice by 15 December 2024.
* Risk assessments are planned to be undertaken by 30 November 2024.
* Consultation will take place with all consumers, representatives and relevant stakeholders regarding the services environmental restrictive practice procedures by 20 December 2024.

In coming to my decision for Requirement 3(3)(a), I have considered the information provided in the assessment contact report and approved provider’s response. While I acknowledge the services planned actions to remediate the deficiencies identified, I am of the view these actions will take some time to be fully implemented and evaluated for effectiveness.

It is my decision Requirement 3(3)(a) is Not 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

Most consumers and representatives provided positive feedback in relation to support provided to enhance their daily living, and said they are supported to maintain relationships and participate in activities of interest to them. Staff demonstrated knowledge of consumers’ daily living preferences and described ways they support consumers to participate in their community within and outside the service. Care documentation reflected consumers’ individual goals and preferences to guide staff in providing services and support to meet consumers’ daily living needs. Consumers were observed participating in activities of interest to them throughout the assessment contact.

I have considered the information provided in the assessment contact report and I have placed weight on effective systems in place to support consumers to participate in their community, maintain relationships with individuals who are important to them, and to participate in activities of interest to them.

It is my decision Requirement 4(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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |

Findings

Consumers and representatives provided positive feedback in relation to the care and services provided. Service documentation evidenced the service has processes in place to replace shifts when unplanned or unexpected leave occurs. The service evidenced alternative clinical care arrangements and escalation pathways including access to the local emergency department and ambulance health service which is located next door to the service. Staff provided positive feedback in relation to the deployed workforce and said they are supported by management to meet the needs of consumers.

I have considered the information within the assessment contact report, and I have placed weight on information including the positive feedback provided by consumers and representatives and strategies the service evidenced to ensure care sufficiency.

It is my decision Requirement 7(3)(a) is Compliant.

Staff did not demonstrate knowledge and understanding of restrictive practice(s) including the required implementation and monitoring processes involved prior to the implementation of a restrictive practice. Service documentation, including training records, evidenced several staff who had not completed or received all mandatory education assigned by the service. The service did not demonstrate a process in place to identify and monitor training and education provided to staff to ensure positive outcomes required under the Quality Standards are achieved.

In response, the approved provider outlined actions the service plans to take to remediate the deficiencies identified including:

* A revised training calendar is planned to be developed and implemented by 15 December 2024.
* Education will be provided to all staff in relation to restrictive practice by 15 December 2024.

In coming to my decision for Requirement 7(3)(d) I have considered the information provided in the assessment contact report and approved provider’s response. While I acknowledge the services planned actions to remediate the deficiencies identified, I have placed weight on the knowledge deficits identified among sampled staff, and service documentation evidencing the service does not have a process in place to ensure the entire workforce is trained, equipped, and supported to deliver positive outcomes required under the Quality Standards. I am of the view the services planned actions will take some time to be fully implemented and evaluated for effectiveness.

It is my decision Requirement 7(3)(d) is Not Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |

**Findings**

The assessment contact reports information is not always consistently shared with relevant staff, and staff and management do not always have access to information to inform improvements. Management did not demonstrate a shared understanding of the service’s electronic care management system, resulting in the lack of reporting, analysis, and review of data and information including call bell response times and relevant policies and procedures.

Service documentation, including the service’s plan for continuous improvement register, evidenced where improvements are identified there is a lack of actions taken in response to areas requiring improvement. For example, the service reported the absence of an infection prevention control lead, however no actions have been planned or implemented to remediate or address the improvement action.

The service did not demonstrate effective systems in place to monitor financial income and expenditure. The organisation did not demonstrate systems to maintain safety and quality of their financial planning to ensure resources the organisation need to deliver safe and quality care and services is available.

The service did not demonstrate appropriate governance of the workforce including oversight of the delivery of education and training, and review of relevant policies and procedures to guide staff in the delivery of safe work practices.

While the service demonstrated compliance with legislative requirements including the 24/7 RN requirement and mandatory care minute target, the service did not demonstrate accurate reporting including the provision of the services care minutes calculation.

Service documentation, including the services feedback and complaints register, evidenced where feedback or complaints are raised, improvement actions are not always addressed, reviewed, and actioned to improve outcomes.

In response to the deficiencies identified, the approved provider outlined actions the service plans to take to remediate the deficiencies including:

* The service is actively seeking to recruit a new Board Advisory Group including an independent clinical advisor to support the clinical and governance oversight of the service.
* The service’s plan for continuous improvement register will be reviewed and updated by 15 December 2024.
* Complaints will be reviewed and reported to the Board moving forward.
* Th service plans to review care minute calculations and education will be provided to relevant staff regarding the fundamentals and processes involved when calculating care minutes.
* Policies and procedures are planned to be reviewed.

In coming to my decision for Requirement 8(3)(c) I have acknowledge the information provided in the assessment contact report and approved provider’s response. While I acknowledge the services planned actions, I am of the view these will take some time to be fully implemented and evaluated for effectiveness.

It is my decision Requirement 8(3)(c) is 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-1)