Performance

Report

**1800 951 822**

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| Name of service: | Shepparton Aged Care |
| Service address: | 29-35 Pine Road SHEPPARTON VIC 3630 |
| Commission ID: | 4357 |
| Approved provider: | Menarock Aged Care Services (Victoria) Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 August 2023 to 18 August 2023 |
| Performance report date: | 8 September 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 Shepparton Aged Care (**the service**) has been prepared by N Eastwood, 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 - 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 6 September 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 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

The service was previously found non-compliant with requirement’s 2(3)(a) and 2(3)(e) following a Site Audit performed between 18 April 2023 to 20 April 2023 (the Site Audit).

At the time of the Site Audit the service did not demonstrate assessments and care planning documents always inform the delivery of safe and effective care in relation to wounds, chemical and mechanical restrictive practices, and changed behaviour.

The Assessment Team recommended requirement 2(3)(a) was non-compliant after the site visit of 17 and 18 August 2023 as there was ongoing concerns related to consumer safety, health, and well-being, specifically related to the use of restrictive practices which were not always assessed and included in care planning documentation. After consideration to additional information submitted by the Approved Provider in response to the Assessment Team report as well as updates to the Plan for Continuous Improvement (PCI) I have come to a different view.

The service has implemented several actions in response to the identified non-compliance with requirement 2(3)(a) including education, care plan consultations and supporting audit, as well as a review of individual consumer assessments. Notwithstanding these improvements the Assessment Team noted that consumers and representatives could not always recall that the risks and alternative solutions for the use of chemical, mechanical, and environmental restrictive practices had been explained. Representatives of consumers subject to chemical restraint indicated they were not aware the consumer was subject to chemical restrictive practices and could not recall providing informed consent for its use.

The Approved Provider submitted a response (the response) and PCI with additional information and evidence of actions taken since the Assessment Contact on 17 and 18 August 2023. The response demonstrates a number of items which have been addressed, specifically associated with the Assessment Teams observations and named consumers. There is evidence of completion of assessment and care planning documentation as well as review of existing support plans and appropriate referrals for General Practitioner completion of restraint related documentation. Education has been provided to staff and evidence of improvement in outcomes for consumers following involvement of external agencies such as Dementia Support Australia and complex wound care regimes.

The service has also implemented several effective actions in response to the identified non-compliance with requirement 2(3)(e), including strengthened policies and processes, daily and monthly documentation reviews and education. Consumers and representatives confirmed consumer care and services were regularly reviewed for effectiveness and staff are knowledgeable about their needs, preference, and goals of care. Management explained how reviews of care planning document are carried out to ensure consumer care is appropriate for current needs. The Assessment Team noted that clinical documentation was reviewed for 9 consumers evidencing care plans are reviewed and updated 3-monthly in accordance with the service’s policy. Clinical incidents such as changed behaviours and pressure injuries are logged and evaluated in a systematic manner.

I acknowledge the inclusion of specific actions in the PCI and commitment to improve safe and effective care as well as consulting with consumers and representatives consistent with review processes. In ensuring these areas remain a continuous improvement priority, the actions included in updates to the PCI should be monitored and evaluated to ensure improvements are sustained in practice.

As a result, and with consideration to the actions implemented and available information I am satisfied that requirement’s 2(3)(a) and 2(3)(e) are now compliant.

# 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)(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 |
| 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

The service was previously found non-compliant with requirement’s 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) following a Site Audit performed between 18 April 2023 to 20 April 2023 (the Site Audit).

At the time of the Site Audit the service did not demonstrate skin integrity or wound management was consistent with best practice, documentation related to the use of restrictive practice was incomplete, effective management of pressure injury and changed behaviours.

The Assessment Team recommended requirement 3(3)(a) was non-compliant after the site visit of 17 and 18 August 2023 as there was ongoing concerns related to consistent wound management documentation, monitoring for healing progress and effective wound care regimes as recommended by a treating specialist.

The service implemented several actions in response to the identified non-compliance with requirement 3(3)(a) including education related to wound management and restrictive practices, assessment reviews and audits of restrictive practice use. The Assessment Team noted some inconsistency in restrictive practice informed consent, monitoring and review. Care documentation did not always demonstrate regular monitoring of consumers for signs of distress or harm, side effects and adverse events, changes in well-being, and functional ability to undertake activities of daily living following the administration of restrictive practices. The organisational policy outlines how the ‘Restrictive methods and practices assessment and authorisation form’ is to be reviewed every 3 months in consultation with representatives and the prescribing practitioner. However, these were not evidenced by the documents reviewed and feedback received from staff and consumers and/or their representatives.

The Approved Provider submitted a response (the response) and Plan for Continuous Improvement (PCI) with additional information and clarification around documentation unavailable at the time of the August site visit as well as revised and completed documentation. The response includes evidence of additional wound management and restrictive practice training. The Approved Provider acknowledged areas for improvement as well as additional actions added to the PCI to ensure timely implementation of localised strategies and opportunity for ongoing evaluation. There are clear strategies in place to address the concerns raised by the Assessment Team, and evidence the Approved Provider has committed to improving care associated with wound management and restrictive practices. There is an active auditing process in place to ensure compliance with newly established processes and evidence of involvement of consumers, representatives and a range of health professionals contributing to the care outcomes for consumers.

The service has also implemented several effective actions in response to the identified non-compliance with requirement 3(3)(b), 3(3)(d) and 3(3)(e), including education related to changed behaviours, review of assessments, daily care documentation review and monthly audits. Consumers and representatives confirm that staff understood risks associated with individual consumers and provided safe care. Staff described risks associated with individual consumers and how they manage these risks according to their role. Management discussed how high impact high prevalence risks are managed through clinical data monitoring, trending, and risk mitigation strategies for individual consumers. Care documentation identified individual consumer high impact high prevalence risks and effective management of pressure injury care and behaviour management. The Assessment Team noted that while there were some ongoing inconsistencies in specific areas of escalating care, there was evidence of improvements adopted by the service in identifying, recognising, and communicating signs of consumer deterioration or changes in condition or capacity as well as implementation and communication of recommendations made by treating practitioners.

As a result, and with consideration to the available information I am satisfied that requirement’s 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) are now compliant.

# 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 |

Findings

The service was previously found non-compliant with requirement 8(3)(d) following a Site Audit performed between 18 April 2023 to 20 April 2023 (the Site Audit).

At the time of the Site Audit the service did not demonstrate effective management of risks such as changed behaviour, pressure injuries and identification of incidents. The service has implemented several actions in response to the identified non-compliance with requirement 8(3)(d) including, regular auditing and monitoring, redirection room plaques, skin integrity audits and targeted training on wound charting, review care plan consultation pressure injury care and behaviour management. The Assessment Team reviewed documentation which demonstrated the service is identifying, managing, and reporting high-impact or high-prevalence risks and ensuring actions to minimise risks are implemented. Staff confirmed changed behaviour, pressure injuries and identification of incidents is managed through education, evaluating implemented strategies, incident reports, feedback from staff, representatives and consumers, assessment updates and the continuous monitoring of quality indicators. Management described how the service manages adverse behaviours from consumers to ensure they do not impact other consumers. The Assessment Team observed supporting information in incident registers, training folders, care documentation, feedback and complaints registers and audit reports. The service has a system in place to collate the data on the electronic care management system reflecting the resident incident register. Resident data which includes Serious Incident Response Scheme (SIRS), and all other incidents is reported to the clinical board every month.

While the Assessment Team noted some ongoing inconsistencies related to effective wound management and restrictive practice processes, the available information supported improvement and ongoing monitoring of evaluation of implemented and proposed actions. As a result, and with consideration to the available information I am satisfied that requirement 8(3)(d) is now compliant.

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)