Performance

Report

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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: | 5 December 2022 to 7 December 2022 |
| Performance report date: | 10 January 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 Catherine Spiller, 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.

# 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 7** Human resources | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | Not applicable as not all requirements have been assessed |

The service was found to be non-compliant following a Site Audit conducted 11 May 2021 to 13 May 2021 in the following Requirements: 2(3)(a), 2(3)(c), 2(3)(d), 2(3)(e), 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), 3(3)(f), 3(3)(g), 8(3)(d) and 8(3)(e).

Following an Assessment Contact conducted 1 December 2021 to 3 December 2021 the service was found to have ongoing non-compliance in the following Requirements: 2(3)(a), 2(3)(e), 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), 3(3)(f), 3(3)(g), 8(3)(d) and 8(3)(e).

The Assessment Team assessed the following Requirements: 2(3)(a), 2(3)(e), 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), 3(3)(f), 3(3)(g), 8(3)(d) and 8(3)(e). Additional Requirements 7(3)(a) and 7(3)(d) were also assessed in response to complaints received by the Commission regarding staff availability, skills and knowledge.

Where the Quality Standard is Met, all requirements of that Quality Standard have been assessed as Met.

Where the Quality Standard is Not Met, one or more requirements of that Quality Standard has been assessed as Not Met. Note that this does not mean that all requirements were 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

I am satisfied that Requirements 2(3)(a) and 2(3)(e) are compliant.

In regard to 2(3)(a), the service was found non-compliant following a Site Audit performed between 11 May 2021 and 13 May 2021 and during a further Assessment Contact from 1 December 2021 to 3 December 2021. The service did not demonstrate that care plans consistently include relevant information about consumer care and that consumers’ risks were not always identified in documentation.

The service has implemented actions to address these deficits which have been effective. The organisation has reviewed and updated their assessment and care planning policies. The service reviewed consumers’ assessments and care plans to include the consumers’ assessed risks and individualised interventions planned with consumers and/or their representatives. Staff education on holistic assessment and care planning was provided. Consumers and/or their representatives are satisfied with consumer care planning and indicated confidence that consumer risks are identified and strategies to minimise harm to consumers are planned. Clinical staff demonstrated knowledge of assessment and care planning processes and how risk is assessed and minimised. Care planning documents contained comprehensive multidisciplinary assessments and individualised care plans utilising a range of validated risk assessment tools to assess and plan consumers’ care with consideration of risks.

In regard to 2(3)(e), the service was found non-compliant with this requirement following a Site Audit performed between 11 May 2021 and 13 May 2021 and during a further Assessment Contact from 1 December 2021 to 3 December 2021. The service did not demonstrate that care and services were reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The service has implemented actions to address these deficits which have been effective. Consumer file review demonstrated the service developed and implemented an effective care review schedule. The Assessment Team reviewed care documentation demonstrating a timely care plan review following a fall, change in mobility, weight loss, pressure injury and escalating changed behaviour. Clinical staff and management described how consumer’s relevant care plan is reviewed following an incident or change in mental or functional capacity. All consumers and/or their representatives indicated they are consulted every 3 months or when consumer’s health needs changed outside of the schedule.

# 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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I am satisfied Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), 3(3)(f), 3(3)(g) are compliant.

The service was found non-compliant with these requirements following a Site Audit performed between 11 May 2021 and 13 May 2021 and during a further Assessment Contact from 1 December 2021 to 3 December 2021.

The service did not demonstrate that consumers’ use of restrictive practices, skin integrity, wounds and pain were effectively managed in accordance with best practice principles.

The service did not demonstrate the effective management of high impact or high prevalent risks including the management of changed behaviours, psychotropic medications, diabetes and other specialised care needs.

The service did not demonstrate effective communication of consumers’ needs and preferences within the organisation and allied health professionals.

The service was unable to demonstrate an effective response to the deterioration of consumers health and well-being in a timely manner.

The service did not demonstrate effective communication of consumers’ needs and preferences within the organisation and allied health professionals.

The service failed to demonstrate specialist referrals were made in a timely manner. Particularly in the areas of wound specialists and a geriatrician.

The service did not demonstrate appropriate infection prevention and control practices.

During this Assessment Contact conducted on 5 December 2022 to 6 December 2022, the Assessment Team found the service has implemented actions to address these deficits which have been effective. Actions including, but not limited to; review and updating of policies, regular wound audits and wound education, providing information on restrictive practices to consumers and representatives and review of behaviour care plans. Staff education was provided on high impact high prevalence risks including nutrition, unplanned weight loss, pressure injury, diabetes, managing consumers living with dementia and infection control practices. The ‘Clinical Deterioration’ policy has been updated and reminders to staff to review the policy and be aware of their roles in managing deterioration. In addition, the ‘Advance Care Plan Directives’ have been updated and reviewed in consultation with consumers and their representatives. The service has improved communication processes to ensure changes to consumer’s condition, care needs, and preferences are communicated to all relevant staff and allied health. Staff interviews and consumer file review confirmed these actions had been implemented are were effective.

# 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. | Compliant |

Findings

I am satisfied the service is compliant with Requirement 7(3)(a) and 7(3)(d).

Consumers and their representatives expressed confidence in the skills and knowledge of the staff and said there are sufficient staff to meet consumer needs and preferences. Rosters viewed reflect vacant shifts are filled through the use of part-time staff. Staff are satisfied with staff levels and commented on how management fills any vacant shifts. Roster documentation demonstrated that vacant shifts over the last month have been filled. The Assessment Team did not identify any unfilled shifts in clinical care staff, lifestyle staff or hospitality services.

Consumers and their representatives expressed satisfaction with staff knowledge and indicated staff are well trained. The organisation has processes to ensure appropriate staff are recruited and provided with orientation and ongoing training. The organisation provides support to the site management team in relation to recruitment, training and orientation of new staff and performance management. The service demonstrated that all staff are recruited based on the required skills and qualifications to fill the role. Formal orientation programs are in place with staff-provided ‘buddy’ or supernumerary shifts supported by face-to-face orientation to their roles and the organisational policies and procedures.

# 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

I am satisfied the service is compliant with Requirements 8(3)(d) and 8(3)(e).

The service was found non-compliant with these two requirements following a Site Audit performed between 11 May 2021 and 13 May 2021 and during a further Assessment Contact from 1 December 2021 to 3 December 2021.

The service did not demonstrate effective risk management systems and practices were in place for high prevalent or high impact risks, relating to dysphagia, behaviours, diabetes management and other specialised clinical care needs.

The service did not demonstrate accurate oversight of the use of chemical restraint. Relevant staff did not demonstrate an understanding of regulatory requirements in relation to the use of restrictive practices, identification of risks associated with falls and monitoring of behaviours following incidents.

During this Assessment Contact conducted on 5 December 2022 to 6 December 2022, the Service demonstrated improved risk management practices and staff knowledge, and effective management of high-impact, high-prevalence risks. Actions to rectify included; a review of psychotropic medications and restraint use with personalised behaviour support plans put in place, formal links to the local INREACH service, completion of outstanding medication management reviews, development of a falls flow chart and education on open disclosure, antimicrobial stewardship and restrictive practices. The Restrictive practice registers demonstrated the service is identifying potential restraint and documenting appropriate reviews and consent. Staff have completed mandatory education on incident identification, SIRs reporting, and psychotropic medication use and restrictive practices.

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)