Brimlea Aged Care

Performance Report

21 Railway Parade   
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Phone number: 03 8564 1060

**Commission ID:** 4503

**Provider name:** Five Star Care Pty Ltd

**Site Audit date:** 20 December 2021 to 22 December 2021

**Date of Performance Report:** 4 March 2022

# Performance report prepared by

James Howard, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit conducted from 20 December 2021 to 22 December 2021; the Site Audit 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 Site Audit report received 15 February 2022.
* Other information and intelligence held by the Commission in relation to this service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant, as six of the six specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, such as:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation and risk assessments.
* The service’s policies and procedures.
* Observations during the site audit.

Overall, sampled consumers advised the Assessment Team they were treated with dignity and respect, supported to maintain their identity and could make informed choices about their care and services to live the life they chose.

The Assessment Team found that consumers’ culture and diversity was valued by the service. Staff were able to explain each consumer’s life journey and personal circumstances, and how consumer preferences influenced the day-to-day delivery of care. Consumers and staff provided examples of how the service embraced individual culture and diversity, values and beliefs in a safe manner.

Staff demonstrated an understanding of consumers’ right to exercise choice and independence. Staff explained, in practical terms, how they supported consumers to make informed decisions about their care and how care should be delivered. Staff also explained how they supported consumers with their decisions to involve, or not to involve, others in their care, and how they supported consumers to communicate their decisions. The Charter of Aged Care Rights was displayed throughout the service.

A review of evidence confirmed consumers were supported in all aspects to exercise choice and independence, and were able to connect with others and maintain relationships of choice. Consumers described their social and personal relationships and how the service supported them to maintain connections, which aligned with care plan documentation.

Consumers were supported to take risks to enable them to live their best life, as verified by consumer interviews, and sampled risk assessments included in care plans, for example, being able to continue to drive. Risk assessments were completed in consultation with consumers, and with representatives and health professionals where applicable. The service’s dignity of risk guideline recognised consumers’ right to make decisions that may affect their lives and be associated with risk.

Consumers and representatives described how the service explained information to them in an accurate and timely manner, and how the information assisted them to make informed choices about their daily care and lifestyle activities. Consumers advised they were able to attend a monthly consumer meeting with the service, and had access to meeting minutes, newsletters and an activity calendar. Site observations and interviews with staff confirmed information was shared through various methods such as emails, texts, posters, brochures, noticeboards, and accounted for communication preferences, for example, Greek translation and cue cards for non-verbal needs.

All sampled consumers advised that they felt their privacy and personal information was respected and kept confidential by the service. The service described in practical terms how it upheld personal privacy and confidentiality, as validated by site observations.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant, as five of the five specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* Consumer feedback surveys, care plan progress notes and applicable medical documentation.

The Assessment Team recommended that Requirement 2(3)(a) and Requirement 2(3)(e) were non-compliant. However, having considered both the evidence presented by the Assessment Team and by the service, I have decided Requirement 2(3)(a) and Requirement 2(3)(e) are compliant, as further detailed under ‘Assessment of Standard 2 Requirements’.

Sampled consumers and representatives advised the Assessment Team that consumers were involved in the ongoing assessment and planning of their care and service delivery needs, to optimise their health and wellbeing.

Overall, review of the service’s electronic care documentation system and assessments in sampled care plans confirmed the service used evidence-based assessment tools to appropriately consider risks to consumers’ health and wellbeing and to inform the delivery of safe and effective care and services to consumers. The Assessment Team noted the absence of pain assessment and management relating to an incident for one consumer. However, the service provided satisfactory evidence that substantiated the consumer’s care needs were assessed, monitored and evaluated during the period in question, as covered under Requirement 2(3)(a).

Sampled care plans identified consumers’ current needs, goals and preferences and included details of advance care directives and end of life planning. The sampled care plans contained relevant information on how the service could support individual requirements, for example behavioural intervention and strategies to assist the consumer. Consumers and representatives confirmed that the service spoke to them about advance care and end of life planning, and respected their decisions.

Registered nurses, clinical staff and other staff explained the initial assessment pathway, how care plans were updated based on changes to consumer needs and how the service involved the medical officer or specialised health professionals in ongoing assessment, planning and review. Staff explained how they partner with consumers and, if requested, representatives to inform care planning, through gathering information about consumers’ life histories, needs, goals and preferences.

Consumers and representatives confirmed that they understood the outcomes of the assessment and planning, and that consumer needs were considered accordingly. Some representatives advised that they did not have a copy of the care plan. However, representatives were satisfied by the information communicated to them by the service, and knew how to obtain a copy of the care plan if required.

The Assessment Team noted one example of care and services not being reviewed based on changes to a consumer’s needs. In response, the service provided satisfactory evidence which substantiated that the consumer was appropriately supported through review and monitoring, after their re-entry to the service following an incident. Referrals to health professionals and assessment and monitoring of pain were completed to support the consumer’s changed needs, as detailed under Requirement 2(3)(e).

Based on the weight of evidence presented by the Assessment Team and service, care and services were reviewed when consumers’ circumstances changed, or were no longer effective. The evidence demonstrated that the service partnered with consumers, representatives and other health professionals to meet the consumers’ needs and used evidence based tools in their assessment.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

Overall, the Assessment Team found that consumer’s care plans demonstrated effective and comprehensive assessment of consumer’s health and well-being to inform the delivery of safe and effective care and services. Sampled care plans identified the needs, goals and preferences of consumers, which aligned with consumer and representative feedback. Consumers and representatives were involved in the care planning process and reported they were satisfied with the care received. Staff were able to explain the assessment and monitoring processes in place to support consumer, including observations, consultation with the consumer and their representatives, assessment tools, referrals to health professionals and involvement of other parties in the delivery of care and services. The service was supported by policies and procedures to guide staff with assessment and care planning for consumers.

The Assessment Team recommended that this requirement was non-compliant due to an example of pain assessments not being completed for a consumer. In response, the service provided evidence of the pain assessments and charting that were completed for the consumer during the dates in question. The supporting evidence demonstrated that pain management and charting were completed during the incident, with revision and monitoring of the consumer’s care needs after. In its written response, the service was able to explain how it supported the consumer before, during and after the incident, through actions such as:

* Service admission assessment by registered nurse, and aged care assessment including of documentation of pain needs and goals.
* Review of consumer’s medical history prior to site admission.
* Referral to the consumer’s general practitioner.
* Assessment by physiotherapist on admission, and further follow up assessment.
* Pain assessment chart throughout the applicable timeframe.
* Electronic care plan system records, monitoring and progress updates.
  + Records of the consumer’s preferences, and participation in social activities to support well-being.

Based on the balance of evidence presented by the Assessment Team and the service, Requirement 2(3)(a) is deemed compliant; the service demonstrated it considered risks to consumer’s health and wellbeing during assessment and planning, to inform the delivery of safe and effective care and services.

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

### Requirement 2(3)(e) Compliant

*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.*

Overall, the Assessment Team found that care and services were reviewed for effectiveness, when circumstances changed, or when incidents impacted on the needs, goals or preferences of consumers. Staff explained that care plans were reviewed every three months, or as necessary, to reflect current consumer needs, goals and preferences. Staff and management explained how they responded to incidents through reassessment and review of care plans using evidence based tools and referrals to health professionals as applicable. For example, the service advised the Falls Risk Assessment Tool was used to assess a consumer after a fall.

However, the Assessment Team recommended Requirement 2(3)(e) as non-compliant due to an example of care planning documentation not including pain assessment and charting after an incident.

In its written response, the service explained the timeline of events and actions taken to support the consumer during and after the incident, including involvement of the consumer’s representative and health services, and notification to the Serious Incident Response Scheme. The service provided supporting evidence that verified appropriate and timely referrals, monitoring and evaluation were undertaken to support the consumer during the incident and after, such as:

* pain interventions clinic record
* neurological monitoring and charting
* progress notes.

The service provided further context around the incident in question, and clarified that the consumer was monitored and evaluated for pain after readmission into the service from hospital. Upon readmission, the consumer reported no complaints of pain, and through assessment did not require medication, as verified from the supporting documentation. To support the consumer, the physiotherapist conducted several assessments, and provided treatment through massage and heat packs, which was recorded in progress notes. The service also supported the consumer’s changed needs, through referral and assessment by a dietician.

Based on the balance of evidence presented by the Assessment Team and the service, Requirement 2(3)(e) is assessed as compliant, as the service was able to demonstrate care and services were reviewed for effectiveness when circumstances changed. **STANDARD 3 COMPLIANT  
Personal care and clinical care**

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant, as seven of the seven specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* Consumer feedback surveys, care plan progress notes, copy of site layout and applicable medical documentation.

The Assessment Team recommended that Requirement 3(3)(a), Requirement 3(3)(d) and Requirement 3(3)(g) as non-compliant. However, having considered the evidence in the site audit report and the evidence provided by the service in its response, I decided Requirement 3(3)(a), Requirement 3(3)(d) and Requirement 3(3)(g) are compliant, as further detailed under ‘Assessment of Standard 3 Requirements’.

Overall, consumers advised that they received personal and clinical care that was safe, met their individual needs and aligned with their goals and preferences.

Staff provided examples of how the service’s policies, procedures and tools applied in practice, and were aligned to best practice guidance. Staff confirmed they had access to evidence-based work instructions, which guided personal and clinical care in a safe and effective manner.

The service documented consumers’ needs and preferences during the assessment and care planning process to inform the delivery of safe and effective personal and clinical care, tailored to individual needs. Clinical staff described individual care requirements for sampled consumers, which aligned with the information in their care plans.

Based on the balance of evidence presented by the service and the Assessment Team, the service demonstrated its personal and clinical care was best practice, tailored to individual needs and optimised consumers health and wellbeing, with respect to restrictive practice, skin integrity and pain management.

The service demonstrated that risks for each consumer including falls, skin integrity and pain were effectively managed through evidence-based assessment and planning, incident documentation and referrals to the medical officer and health professionals as required.

Sampled care plans included information about advance care and end of life care directives as applicable. Consumers and representatives advised that end of preferences and directives were respected by the service

Staff described how they recognised and responded to deterioration or changes in a consumer’s mental health, cognitive or physical function. The service demonstrated how it effectively shared information about the consumer’s condition, needs and preferences within and outside the organisation through shift handovers, care plan record management, case conference notes and involvement of consumers, representatives and other health professionals as required. Staff described how they identified and completed timely and appropriate referrals to other health professionals, as backed by supporting evidence from the service

Staff, including the service’s infection prevention and control lead, described the processes in place to minimise infection related risks. They described the service’s practices to promote appropriate antibiotic prescribing and strategies in place to reduce risk of resistance to antibiotics. The Assessment Team confirmed staff were supported to understand the risks associated with infections through staff training and infection control policies, instructions and guidance.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*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.*

Overall, consumers and representatives considered that consumers received safe and effective personal and clinical care that was best practice, tailored to individual needs and optimised health and wellbeing. Staff were able to explain how they involved other services and providers of care to support consumer’s clinical and personal care, such as physiotherapists, podiatrists and other health professionals. The service identified that most consumers received pressure injury management, and used strategies such as repositioning, or devices to assist with care.

Management described strategies that the service used to manage behaviour and restraint minimisation. The service involved Dementia Services Australia (DSA) to guide the service in the implementation of non-pharmacological strategies, and review of medications. Staff and consumers were supported by written policies to minimise the use of restrictive practice to ensure care and services aligned with best practice principles.

The service demonstrated that it applied consistent best practice methods for ensuring skin integrity, and supported staff through policies and procedures. The Assessment Team also demonstrated that they used evidence based tools and scales, such as the abbey pain scale, to assess consumers experiencing pain.

However, the Assessment Team recommended Requirement 3(3)(a) as non-compliant for the following reasons:

* Example 1: The Assessment Team considered that best practice, tailored clinical care was not considered through the monitoring and evaluation of one consumer after an incident.
* Example 2: The Assessment Team considered the service was unable to demonstrate how it considered the effectiveness of non-pharmacological interventions for one consumer.
* Example 3: Two medications were not recorded on the service’s psychotropic medication register.

Example 1

The service provided further information about the incident mentioned by the Assessment Team in the site audit report. It advised that the Serious Incident Response Scheme was notified of the incident within the required timeframe. The service outlined the timeline of events, actions taken during and after the incident, and strategies used to assess, monitor and review the consumer’s care needs such as pain management charting. Supporting evidence was submitted to substantiate the service’s statement of claims. On the basis of the further information provided, I have decided that the service followed the appropriate steps in place to care for the consumer, in a manner that was best practice, tailored to needs and optimised health and wellbeing, aligned with the service’s risk management policy.

Example 2

In response to the Assessment Team’s feedback about the effectiveness of non-pharmacological interventions for a consumer, the service provided further context about the clinical care of the consumer. The service outlined the timeline of events, strategies they used to explore non-pharmacological options, information about the referral process and other stakeholders involved such as the general practitioner and family.

The service explained why certain non-pharmacological options were explored, how non-pharmacological options were reviewed for effectiveness, and what strategies were in place to support the consumer, such as a behaviour support plan reviewed every three months. The statement of claims provided by the service was substantiated by supporting evidence, such as medical documentation. On the basis of the further information provided, I decided that the service considered best practice, tailored clinical care, to optimise the health and wellbeing of the consumer.

Example 3

During the site audit, the Assessment Team identified that the service did not record two psychotropic medications on the psychotropic medication register for a consumer. In response, during the site audit, the service advised that its pharmacy did not classify them as psychotropics. In the service’s written response, it advised that a continuous improvement activity was undertaken to address the discrepancy in the psychotropic medication register, and appropriate stakeholders were informed such as the service’s medication advisory committee and pharmacy. The service also provided supporting evidence to substantiate its claims, and acknowledged the Assessment Team’s feedback in relation to the psychotropic register. Having considered the service’s remediation of the psychotropic register and that there was no identified negative impact to consumers, I decided that this is an area of improvement but does not warrant a finding of non-compliance for Requirement 3(3)(a).

In addition to the supporting evidence submitted by the service, several examples were provided throughout the site audit report which demonstrated that consumers received safe and effective personal and clinical care that aligned to best practice principals, tailored to needs and optimised their health and wellbeing. Based on the balance of evidence presented by the Assessment Team and the service, I decided Requirement 3(3)(a) is compliant.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

The Assessment Team recommended Requirement 3(3)(d) as non-compliant, based on the Serious Incident Response Scheme example mentioned under Requirement 2(3)(e) and Requirement 3(3)(a).

As addressed under Requirement 2(3)(e) and Requirement 3(3)(a), the service provided information which substantiated that the consumer received care and services in a timely manner, in accordance with the consumer’s needs. The service outlined the timeline of events, actions taken during and after the incident, and strategies used to assess, monitor and review the consumer’s care needs such as pain management charting. Having considered both the material in the site audit report and the evidence in the service’s response, I have decided that Requirement 3(3)(d) is compliant.

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

The service demonstrated how it minimises infection-related risks through implementing standard and transmission-based precautions to prevent and control infection. The service also demonstrated that that it had sufficient processes in place to promote appropriate antibiotic prescribing and to reduce the risk of increasing resistance to antibiotics. The service had an infection protection control lead with oversight of the outbreak management plan, monitoring of government regulations, personal protective equipment use and supply, staff education and managing the service’s influenza and COVID-19 vaccination program. Staff explained how the service’s antimicrobial stewardship principles applied to clinical care, and the strategies that were in place to evaluate the effectiveness of antibiotics.

However, the Assessment Team recommended Requirement 3(3)(g) as non-compliant due to feedback about a donning and doffing station not being present in the main staff room, and observations about mask wearing.

As observed during the site audit, the service was separated into different zones, through the coded doors, to minimise the risk of infection transmission. The service advised it submitted an outbreak management plan, inclusive of zoning requirements, to the Department of Health, the Victorian Aged Care Response Centre, and the Victorian Department of Health and Human Services.

In response to the Assessment Team’s feedback about the donning and doffing station, the service clarified in its written response that donning and doffing stations were available throughout the service in different zones. The service’s main staffroom was not in use due to zoning requirements, which is why there was no donning and doffing station in the staffroom. The service provided a site layout, which confirmed donning and doffing stations were present throughout the zones.

In the site audit report, the Assessment Team noted that masks were not worn consistently by some management staff. In response, the service advised it was not informed of this feedback during the site audit and would have addressed the situation if it was informed. Further, the service noted it did not recall any occurrences of incorrect mask usage during the site audit.

The service advised it had personal protective equipment monitoring processes in place, with oversight from the infection protection control lead. As the Assessment Team did not provide specific details of the alleged incorrect mask use, and no feedback was provided during the site audit, I have decided that the material in the site audit report is insufficient to substantiate grounds for non-compliance. The Assessment Team did not raise any other matters relating to infection control.

As the service provided further context to the feedback about the donning and doffing station, mask use, and infection control processes were in place during the site audit, I have decided Requirement 3(3)(g) is compliant.

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant, as seven of the seven specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, such as:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation, including progress notes and assessments.
* Review of the lifestyle activity program.
* The service’s policies and procedures.
* Observations during the site audit.

Overall, sampled consumers advised they received safe and effective services and supports for daily living that were important for their health and wellbeing, and enabled them to do the things they wanted to do. Staff described individual consumer preferences, and how they supported consumers with their emotional, spiritual and psychological wellbeing.

Sampled care planning documentation included strategies to assist with consumer’s psychological wellbeing, such as including consumers in one-to-one conversations, supporting them to telephone their families, referral to counselling when necessary and supporting them to attend activities of interest. The Assessment Team observed staff kindly and attentively interacting with consumers, for example by playing crosswords with them.

Consumers advised the service supported them to participate in their communities, have social and personal relationships and do things of interest to them.

Staff described the processes and systems in place to record and share information within and outside the organisation about consumers’ conditions, needs and preferences, and this was validated by review of care plans and site observations.

Staff provided examples of lifestyle and daily living supports that met the needs, goals and preferences of consumers, for example:

* Church and coffee catch-up after the service.
* ‘Religious week’ initiative to support different denominations within the service.
* Visits from community volunteer groups to build social relationships.
* Lifestyle activities at the service such as arts and crafts, bread baking and chair yoga.
* ‘Elders at ease,’ a mental health wellbeing program, facilitated by a group of specialists.

Consumers advised they were satisfied with the quality and quantity of meals provided at the service, their dietary needs and preferences were catered for, and they could provide feedback to staff about the meals. Consumer’s dietary requirements were reviewed and documented by a dietician as required. Hospitality staff monitored dietary requirements by including information on a whiteboard in the kitchen, on meal trolleys and in consultation with clinical and care staff. Staff were able to explain the processes in place to ensure equipment was safe, clean and well maintained, as verified by observations by the Assessment Team.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant, as three of the three specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff at the service.
* Review of the maintenance and cleaning logs.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* Consumer feedback surveys, site layout plan and reference to guidance and legislative requirements for COVID-19.

The Assessment Team recommended that Requirement 5(3)(b) was non-compliant. However, having considered the evidence presented by the Assessment Team in the site audit report and by the service in its response, I have decided Requirement 5(3)(b) is compliant, as further detailed under ‘Assessment of Standard 5 Requirements’.

Overall, sampled consumers advised that the service environment felt like home, and that it was welcoming, easy to understand and navigate, safe and comfortable. For example, a consumer advised they felt at home and comfortable at the service, and that their friends felt welcome to visit, with private space provided they could sit with visitors. Observations showed the service environment reflected dementia-enabling principles of design and optimised consumers’ interaction and experience within the service, such as:

* Clear and easy to see emergency exit signage.
* Pathways free of hazards, no uneven surfaces and rail guards on walls.
* Easily identifiable room numbers and signage.

Consumers advised that the service environment was safe, clean and well maintained, which aligned with observations during the site audit. Staff explained how the service environment was cleaned, maintained, and the processes in place to identify and respond to faults. Management provided evidence of a recent maintaince job, that demonstrated it was resolved in a timely manner and recorded in the maintaince log, in line with the service’s policies. Furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumers, which aligned with consumer feedback. The Assessment Team observed chemicals and cleaning supplies were safely stored, and restricted to staff access only in the basement.

Consumers advised that service environment allowed them to move freely about. However, the Assessment Team recommended Requirement 5(3)(b)(ii) as non-compliant due to locked coded doors throughout the service.

In its written response, the service clarified that the locked, coded doors were a response to COVID-19 public health directives, guidance and legislative requirements from Commonwealth and state governments. In response to the COVID-19 pandemic, the Victorian government issued guidance regarding ‘Creating COVID-19 zones in residential aged care’, as observed during the site audit. The service provided a blueprint of its different zoning areas, in line with current infection control protocols and guidance. In addition, the service also advised that consumers and representatives were provided access codes for the doors.

Based on the weight of evidence presented by the Assessment Team and service, I decided Requirement 5(3)(b)(ii) was compliant. The service was able to demonstrate consumers’ access of the environment was balanced against the public health orders and guidance in place, and enabled movement through the provision of access codes. Further justification is provided under ‘Assessment of Standard 5 Requirements.’

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

Consumers advised that the service environment was safe, clean, well maintained and comfortable, and allowed them to move around freely. However, the Assessment Team recommended Requirement 5(3)(b)(ii) as non-compliant, due to locked, coded doors which restricted access to different zones in the service environment.

In its written response, the service clarified that the locked, coded doors were in response to the COVID-19 pandemic and active public health directives in place, guidance and legislative requirements from Commonwealth and state governments. In response to the COVID-19 pandemic, the Victorian government issued guidance regarding ‘Creating COVID-19 zones in residential aged care’. As observed during the site audit, the service was separated into different zones, through the coded doors, to minimise the risk of infection transmission. The service advised that they have submitted their outbreak management plan, inclusive of zoning requirements to the Department of Health, the Victorian Aged Care Response Centre, and the Victorian Department of Health and Human Services.

Supporting evidence provided by the service included consumer feedback surveys, a site layout plan and reference to guidance and legislative requirements for COVID-19.

The service demonstrated that consumer access to the service environment was balanced against the public health orders and guidance in place, and that consumers were enabled to move freely through the provision of access codes to consumers and representatives. In response to the zoning, the service advised it had processes in place to support resident’s social interaction within their zone and they were able to interact with others in the facility and maintain communication with family and community. Having considered the evidence in the site audit report and in the service’s response, I have decided Requirement 5(3)(b) is compliant.

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant, as four of the four specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies, procedures and guidance materials.
* Observations during the site audit.
* Review of the service’s feedback and complaints register.
* Review of meeting minutes.

The service’s written response to the site audit, specific to this requirement, was supported by a copy of a consumer survey conducted in August 2021.

The Assessment Team recommended that Requirement 6(3)(d) was non-compliant. However, having considered the evidence in the site audit report and in the service’s response, I have decided Requirement 6(3)(d) is compliant, as further detailed under ‘Assessment of Standard 6 Requirements’.

Sampled consumers gave examples of how they provided feedback or raised complaints, and confirmed their satisfaction with how the service resolved issues or incorporated feedback into the delivery of care and services. Complaints and feedback forms were available in English and Greek, to support the culturally diverse needs of the service. Consumers were supported to understand and use the service’s feedback and complaints framework through methods such as:

* Advocacy posters throughout the service.
* Suggestion boxes throughout the service.
* Written and verbal feedback and complaints options, including the option to submit anonymous feedback.
* Language and advocacy services.

Management advised that alternative feedback and complaints pathway options were communicated to consumers and representatives within service newsletters, consumer and representative meetings, handouts and noticeboards. Consumers and their representatives confirmed they were aware of internal and external resolution processes to resolve complaints. The Charter of Aged Care Rights was displayed throughout the service in both English and Greek, as were complaints avenue posters. Staff were supported to understand barriers in raising complaints through the service’s complaints and advocacy policy, including topics such as; diversity, culture, poor vision and hearing, and cognitive impairment. The policy included guidance to inform consumers of complaints process, support to make complaints and how to incorporate feedback from residents.

Management advised that complaints mainly related to food, and explained the steps undertaken to resolve issues and to incorporate feedback. Consumer interviews confirmed that feedback regarding food had improved.

Staff explained what the open disclosure process meant to them, and how it applied in practice. Staff, consumers and representatives were supported by an open disclosure policy which detailed the actions required to remediate feedback and complaints.

The Assessment Team noted that the service’s register contained minimal records of feedback and complaints, and considered whether this could potentially impact the accurate capturing of data to improve services. On this basis, the Assessment Team recommended Requirement 6(3)(d) as non-compliant.

However, having considered the evidence presented by the Assessment Team and the service, I consider the service demonstrated that feedback and complaints were incorporated into the improvement of care and services.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

In its report, the Assessment Team advised the service’s register contained minimal entries for feedback and complaints and considered it may potentially impact the service’s ability to accurately capture data to improve services. On this basis, the Assessment Team recommended Requirement 6(3)(d) as non-compliant.

However, throughout the site audit report, the Assessment Team presented consumer and staff evidence that showed feedback and complaints were used to improve the quality of care and services.

For example, the service advised the Assessment Team that a representative made a complaint about psychological support required for a consumer with dementia. The representative reported that the consumer was unfamiliar with staff members and that it may cause anxiety. It was requested that staff introduce themselves every time they interacted with the consumer. In response, staff acknowledged the representative’s feedback about staff introductions and incorporated it into the care of the consumer. Staff provided updates of the consumer’s care needs through text message and phone calls to the representative, and provided assurance that the feedback was incorporated into care and services.

In response to the Assessment Team’s site audit report, the service clarified that complaints were documented on a feedback form, available in English and Greek, with verbal complaints recorded by staff. The service advised it has a 24 hour turn-around time to resolve complaints, and any identified issues are documented in the service’s continuous improvement plan. The service used a ‘Moving on Audits’ system to assess, monitor and benchmark its service performance, including the benchmarking of complaints with similar providers. A report from a consumer survey conducted in August 2021, specific to Standard 6, advised that consumers had a 100% level of satisfaction that feedback and complaints were incorporated into improvement of care and services.

Overall, the service demonstrated that feedback and complaints were consistently used to improve service delivery throughout the multiple examples provided in the site audit report. In addition, the service explained how feedback and complaints were recorded, resolved, and used to inform improvements. The service demonstrated that staff understood the service’s complaints management policy and could apply it in practice.

Having considered the information in the site audit report and in the service’s response, I decided Requirement 6(3)(d) is compliant.

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Compliant, as five of the five specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, such as:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of staff rosters, orientation program, training records and appraisal schedule.
* The service’s policies and procedures.
* Observations during the site audit.

Sampled consumers advised they received care and services from staff who are knowledgeable, capable and caring and felt confident that the workforce was appropriately staffed.

Overall, consumers were satisfied with the staffing levels at the service. A review of workforce planning documentation showed there were adequate staff available for all shifts, with appropriate qualifications and knowledge. The service manager confirmed there were no staff shortages, and if shifts were vacant they were primarily backfilled by staff, otherwise agency staff were utilised.

Consumers advised that staff treated them in a kind, caring and respectful manner, and understood their life journey, culture and diversity. Staff demonstrated an in-depth understanding of the consumers, which aligned with consumer interviews and care plan documentation.

The service’s structured recruitment process ensured that staff had the required qualifications, training and credentials to effectively perform their role. Credential and reference checks were conducted before staff were onboarded.

The service supported staff to perform their roles effectively through mandatory training that was recorded in an education register, staff appraisals, and service policies and procedures. The service had a team of internal auditors which evaluated clinical and non-clinical aspects of care and identified areas for further training. Staff explained what the Serious Incident Response Scheme was and described the required actions for incident management, in addition to changes to restrictive practices under the Aged Care Act.

Management advised that staff appraisals were conducted every 12 months to discuss the staff member’s position, goals and training needs. If minor performance issues were identified, clinical management provide support and guidance to staff. Staff, consumer and representative feedback was also used to address performance. Staff advised the Assessment Team that they had no concerns with going to management to discuss issues and to participate in appraisals. The Assessment Team observed that staff demonstrated a shared understanding of their roles and responsibilities.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant, as five of the five specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff, management and board members at the service.
* Observations during the site audit.
* Review of staff rosters, training records and performance appraisals.
* Review of the service’s policies and procedures, for example:
  + risk governance framework
  + clinical governance framework
  + antimicrobial stewardship policy
  + minimising use of restraint policy
  + open disclosure policy.

The service’s written response to the site audit included evidence such as:

* Consumer feedback surveys, care plan progress notes and applicable medical documentation.

Overall, sampled consumers and their representatives reported the service was well run, and their input was used to improve care and service delivery. The service was supported by a wider organisation that provided policies and procedures to guide organisational governance systems. Interviews with management and review of documents confirmed that the service’s governing body promoted a culture of safe, inclusive and quality care and services, accountable for delivery. The governing body advised that change was driven by feedback and reporting from advisory committees and forums.

The service demonstrated it had effective governance systems that accounted for information management, continuous improvement, financial governance, workforce governance and regulatory compliance.

However, the Assessment Team recommended Requirement 8(3)(c)(vi) “feedback and complaints” as non-compliant, due to the non-compliant recommendation under Requirement 6(3)(d) regarding the use of feedback and complaints to improve service delivery. Having considered the information in the site audit report and the service’s response, I have decided Requirement 8(3)(c)(iv) is compliant, as further detailed under ‘Assessment of Standard 8 Requirements’.

The service was supported by a wider organisation that provided policies and procedures to guide organisational governance systems. The organisation’s governing body demonstrated that it promoted a culture of safe, inclusive and quality care and services, and was accountable for its delivery. The governing body advised that change was driven by feedback and reporting from several advisory committees and forums.

The service demonstrated its risk management systems accounted for the management of high impact risks associated with care, identified and responded to abuse and neglect, and managed and prevented incidents. Management and staff explained what they would do if they witnessed an incident, the reporting mechanisms to the Serious Incident Response Scheme, and steps for remediation.

Review of the service’s clinical governance framework confirmed that appropriate processes and risk mitigation strategies were in place for antimicrobial stewardship and infection minimisation. The Assessment Team recommended that the minimisation of restraint under Requirement 8(3)(e)(ii) was non-compliant. However, based on the weight of the evidence, the service demonstrated regulatory compliance with restrictive practices, and the minimisation of restraint. Further information about Requirement 8(3)(e) is covered under ‘Assessment of Standard 8 Requirements’. Staff explained what open disclosure meant to them, how it applied in practice, and how it related to the service’s policies and procedures.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

The service demonstrated that it had effective governance systems relating to information management, continuous improvement, financial governance, workforce governance and regulatory compliance.

Staff could access information they needed to perform their role and were supported by the service’s policies and procedures. The service’s information management policy guided staff on maintaining information systems, protecting privacy and confidentiality of information, securely storing information and when it was appropriate to share information.

The service’s continuous improvement plan was informed by the Aged Care Quality Standards, policies and procedures, internal and external audit teams, feedback from complaints and feedback forms, surveys and consumer meetings. Staff were able to provide an example of how open disclosure and transparency, and consideration of risk to consumer health and wellbeing, informed change within the service.

Management advised that outside the budget process, there were mechanisms in place to consider additional expenditure to meet the needs of consumers. Under workforce governance, the service had effective human resource processes in place for workforce governance to hire and manage staff, with clear lines of responsibility and accountability.

The service demonstrated knowledge of regulatory requirements and how they applied to care and service delivery, such as the Serious Incident Response Scheme and restrictive practice. The workforce was supported to understand regulatory compliance through training, notification of updates through staff communication, audits and incident reviews and the service’s regulatory compliance policy.

However, the Assessment Team recommended Requirement 8(3)(c)(vi) “feedback and complaints” as non-compliant, as it had recommended Requirement 6(3)(d) be found non-compliant, regarding the use of feedback and complaints to improve service delivery. The Assessment Team found that the complaints and feedback register did not contain many entries and considered whether data was appropriately recorded to inform improvements for care and services.

In response to the site audit, the service provided a satisfactory explanation and supporting evidence that demonstrated how feedback and complaints were documented, actioned and used to inform change. In addition, the site audit report contained multiple examples of how the service used feedback and complaints to improve care and services. Having considered the information in both the site audit report and the service’s response, I have decided Requirement 8(3)(c) is compliant.

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

The service demonstrated that its clinical governance systems ensured quality and safe clinical care that promoted antimicrobial stewardship and use of the open disclosure processes. Staff demonstrated knowledge of antibiotic resistance and explained scenarios of appropriate antibiotic usage as verified from care plan documentation. Staff explained how they used an open disclosure process when providing clinical care. The service supported staff to perform their roles through a clinical governance framework, and guidance and policy relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff were also supported by a clinical governance committee that had oversight of the management of clinical risks, clinical practice and staff education. The service monitored the implementation of its infection control policies by maintaining records of influenza and COVID-19 vaccinations, COVID-19 check in procedure and appropriate use of personal protective equipment.

However, the Assessment Team recommended Requirement 8(3)(e)(ii) “minimising the use of restraint” as non-compliant based on two examples covered under Requirement 3(3)(a):

* Example 1: The effectiveness of non-pharmacological interventions for one consumer.
* Example 2: Missing record management of the psychotropic medication register.

Example 1

In response to the site audit report, the service provided further context regarding the clinical care of the consumer and effectiveness of non-pharmacological interventions, with detail of the timeline of events, strategies they used to explore non-pharmacological options, information about the referral process and other stakeholders involved such as the general practitioner and family.

The service explained why certain non-pharmacological options were explored, how it monitored and reviewed non-pharmacological options for effectiveness, and what strategies were in place to support the consumer, such as a behaviour support plan reviewed every three months. The statement of claims provided by the service, was validated against supporting evidence, such as medical documentation. On the basis of the further information provided, I decided that the service considered best practice, tailored clinical care when reviewing the effectiveness of restrictive practice strategies for the consumer.

Example 2

The Assessment Team identified during the site audit that the service did not record two psychotropic medications on the psychotropic medication register for a consumer. In response, during the site audit, the service advised that its pharmacy did not classify them as psychotropics. In the service’s written response, it advised that a continuous improvement activity was undertaken to address the discrepancy in the psychotropic medication register, and appropriate stakeholders, such as the service’s medication advisory committee and pharmacy, were informed. The service also provided supporting evidence to substantiate its claims. Having considered the service’s remediation of the psychotropic register and no identified negative impact to consumers, I decided this is an area of improvement, but is insufficient to make a finding of non-compliance.

Overall, based on the balance of information presented by the service, the service demonstrated it had effective clinical governance systems in place relating to antimicrobial stewardship, the minimisation of restraint and open disclosure. Having considered the evidence in the site audit report and in the service’s response, I decided Requirement 8(3)(e) is compliant.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.