Eyre Peninsula Old Folks Home

Performance Report

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**Commission ID:** 6046

**Provider name:** Eyre Peninsula Old Folks Home Inc

**Assessment Contact - Site date:** 10 November 2021 to 12 November 2021

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

# Performance report prepared by

Andrea Hopkinson, 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

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(e) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(e) | Non-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 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 Contact - Site report received 7 December 2021.

# STANDARD 2 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

This Standard was found Non-Compliant following a Site Audit conducted on 10 to 12 March 2021 in relation to Requirement (3)(e), as the service was unable to demonstrate consumers’ care and services were regularly reviewed when circumstances changed or when incidents impacted on their needs, goals, or preferences.

At this Assessment Contact, the Assessment Team recommended Requirement (3) (e) as Met. The Approved Provider submitted a response in relation to the Assessment Team’s report.

Based on the information before me, I find the service Compliant in this Requirement. The reasons for my decision are outlined below.

An overall rating of the Standard has not been provided as only one of the five Requirements were assessed.

## Assessment of Standard 2 Requirements

### 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.*

The Assessment Team found the service was able to demonstrate care and services were reviewed regularly for effectiveness and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer. The Assessment Team provided the following information and evidence relevant to my finding:

* Overall sampled consumers considered they felt like partners in the ongoing assessment and planning of their care and services. Four consumers sampled were able to describe their involvement in care plan reviews and three representatives said they were updated following incidents and kept informed in relation to changes in care.
* In response to the identified Non-Compliance, the service had implemented several actions which included a review of policies and procedures, completion of internal audits and the provision of education for staff in relation to pain and sleep assessments and weight loss management. The service also had implemented a new reassessment tool (Resident of the Day) designed to capture any changes to consumers' needs or goals monthly.
* Clinical staff were able to describe the process of reassessments and care staff advised they were informed of when a consumer’s care plan/assessment was reviewed and any changes to their care through the service’s electronic system.
* The service was able to demonstrate assessments were completed and evaluated including sleep, pain and behaviour management and changes were made to consumers’ assessments and care plans when required.

However, I note the Assessment Team brought forward information under Standard 3 Requirement (3) (a) regarding the reporting of behavioural incidents to support a review of behaviour management strategies. Although I am concerned that a selected number of incidents had not been captured, investigated or used to support the evaluation of behaviour management strategies, given the broader concerns surrounding restrictive practices and use of behaviour support plans, I have given greater weight to this information under Standard 3 and Standard 8. Furthermore, I acknowledge the Approved Provider’s response outlined additional communication had been provided to staff to remind them of their responsibilities for completing incident forms.

* The service had a care plan review schedule which showed all consumers’ six-monthly reviews were scheduled to registered nurses and an alert system was in place to identify which consumers were due for reassessment. Although the Assessment Team noted some inconsistencies in a consumer’s assessments, staff were able to demonstrate they knew the consumer including their mobility needs.

Based on the information before me, I find the service Compliant in this Requirement.

# STANDARD 3 NON-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

This Standard was found Non-Compliant following a Site Audit conducted on 10 to 12 March 2021 for Requirements (3)(a) and (3)(b) as the service was unable to demonstrate each consumer received safe and effective personal care or clinical care that was best practice, tailored to their needs and optimised their health and wellbeing, Furthermore the service was also not able to demonstrate the effective management of high impact or high prevalence risks. The specific areas of Non-Compliance related to the management of wounds, diabetes and weight loss.

At this Assessment Contact, the Assessment Team recommended Requirement (3) (a) as Not Met and (3) (b) as Met. The Approved Provider submitted a response in relation to the Assessment Team’s report.

Based on the information before me, I find the service Non-Compliant in (3) (a) and Compliant in Requirement (3) (b). The reasons for my decision are outlined below.

The Quality Standard is assessed as Non-Compliant as one requirement has been assessed as Non-Compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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.*

The Assessment Team found in relation to previous concerns identified at the Site Audit in March 2021, the service had implemented a number of improvements in relation to wound care and diabetes management, there had been increased monitoring by the service and care documentation reviewed confirmed appropriate care was being delivered in relation to these areas.

However, the Assessment Team found the service was unable to demonstrate each consumer received safe and effective care that was best practice, tailored to their needs and optimised their health and wellbeing specifically in relation to use of restrictive practices, review of strategies for their effectiveness and implementation of behaviour support plans. The Assessment Team provided the following information and evidence relevant to my finding:

* The service did not effectively identify consumers who were subjected to a restrictive practice (environmental or chemical) and/or ensure that appropriate assessments had been completed. For example:
  + The service had two memory support units which provided a secured living environment for a total of 32 consumers. Of the 32 consumers, the service was not able to demonstrate the use of a restrictive practice (environmental) had been assessed/completed for each consumer.
  + In a third area of the service, one consumer was identified as having an environment restraint assessment completed due to their exit seeking behaviours and the requirement to lock doors in the afternoon each day. However, the service was not able to demonstrate it had reviewed/considered the impact of this on the remaining 17 consumers.
  + Six consumers were identified as being prescribed a psychotropic medication for anxiety or agitation. All six consumers had not been identified as being subjected to a restrictive practice (chemical).
  + The service had also implemented a new psychotropic medication consent form (July 2021), however the service was still in the process of completing these forms at the time of the Assessment Contact.
* Behaviour support plans did not include information regarding individualised strategies to guide staff prior. For example:
  + For Consumer A, general triggers and strategies had been identified, however they did not explain or outlined specific details on how these were relevant for the consumer.
* Incidents documented in the behaviour charting and progress notes were not identified as an incident and the service was unable to demonstrate incidents had been investigated and action taken to support the review of strategies. For example:
  + For Consumer B, there were two incidents in June 2021 of the consumer reported to hit out or hit staff during activities of daily living. The Assessment Team noted no incident reports had been completed.
  + For Consumer C, behaviour charting and progress notes between August and September 2021 identified seven occasions where the consumer showed physical aggression such as hitting, pushing and grabbing staff and/or consumers.
    - In August 2021 progress notes identified the consumer received a psychotropic medication stating ‘hitting and grabbing other residents’, however the service was unable to provide an incident report or demonstrate an investigation had occurred.
    - In September 2021, a progress note stated the consumer’s behaviours had increased over the weekend with agitation and hitting out’, however did not state if this was towards staff or other consumers or identify any incident reports had been completed over the weekend.
  + Staff confirmed they do not complete incident reports, other than record in the behaviour chart and notify the nurse on duty. Furthermore, the Assessment Team noted that the effectiveness or ineffectiveness of strategies were not captured within the consumers’ behaviour support plans to manage behaviours that may impact on others.
* The Assessment Team also noted audits completed did not identify any gaps in behaviour support plans or demonstrate follow up had occurred where staff had noted difficulty in spending time with consumers in relation to the management of behaviours.

The Approved Provider submitted a response in relation to the Assessment Team’s findings. Its response did not refute the Assessment Team’s findings and as part of its response included a plan for continuous improvement which outlined follow up actions undertaken to address the identified deficiencies. Its response identified:

* In relation to consumers residing in secure areas and the use of restrictive practices (environmental and chemical), the Approved Provider identified:
  + An assessment of consumers was required and behaviour support plans including restrictive practice assessments would be completed in consultation with consumers and their appointed decision makers. It also submitted evidence of 35 consumer authorisations and behaviour support plans had since been completed.
  + One consumer located in the third area of the service had since been relocated to the secure unit and doors were no longer being locked in the afternoon.
  + Policies and procedures had been updated in relation to the use, minimisation of restrictive practices, managing behaviour and psychological symptoms of dementia and behaviour support planning.
  + Restrictive practices and behaviour support planning regulations, practices and tools had been incorporated into the annual competency training sessions for all cares and nursing staff.
  + Additional education was being provided to staff through the use of webinars, flyers and guides and information for consumers and their representatives were to be distributed through emails and displayed throughout the service.
  + The service’s restrictive practices annual audit had been amended and an audit conducted in December 2021 which reported staff were aware of their responsibilities, consumers and representatives were educated and involved in the process and policies and procedures were current and accessible.

I note overall consumers were satisfied with care they received and acknowledge the improvement actions being implemented by the service for wound and diabetes management and the subsequent improvements actions in relation to the restrictive practice assessments and behaviour support plans. Although the service’s plan for continuous improvement identifies these actions have been completed and further evidence of consumer care documentation submitted, at the time of the Assessment Contact the service was not able to demonstrate effective processes were in place in relation to these matters to demonstrate care was based on best practice, tailored to the consumer or considered their wellbeing.

I am concerned that multiple consumers living in a secure environment did not have an assessment completed for the use of a restrictive practice, behaviour support plans did not consistently include individualised information about triggers and strategies and incidents were not used to assist in the review and evaluation of strategies. Therefore, based on the information before me I find the service Non-Compliant in this Requirement.

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

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

The Assessment Team found the service was able to demonstrate the effective management of high impact or high prevalence risks. The Assessment Team provided the following information and evidence relevant to my finding:

* Overall sampled consumers considered that they received care that was safe and right for them.
* In response to the previous areas of the Non-Compliance, the service had implemented several actions which included:
  + A review of the mini nutritional assessment form to capture additional information about consumers’ body mass index in their care plan.
  + Weight management protocols reviewed, and monthly weight reports completed to assist in monitoring interventions.
  + The service had reviewed the new computer documentation system which now triggers an alert prompting staff to review the consumer and commence appropriate actions in a timely manner.
  + Clinical staff stated changes to the clinical summaries have been amended to include weight management for all consumers. Clinical summaries reviewed for September 2021 demonstrated clinical staff monitored consumers’ weights, reviewed contributing factors and action was taken.
* The Assessment Team reviewed the file of a consumer with weight loss which showed ongoing monitoring and involvement of key stakeholders in decisions regarding care, including when they were commenced on end of life care.
* The service held regular care staff meetings where consumers at risk were identified and strategies discussed. Examples related to the provision of texture modified diets, depression and exit seeking behaviours.
* Staff demonstrated they knew their consumers well and were able to demonstrate awareness of consumers who were high risk and what strategies they have implemented at ensure they remained safe, and this was reflected in the consumers’ notes and care plans.

Based on the information before me, I find the service Compliant in this Requirement.

# STANDARD 4 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

This Standard was found Non-compliant following a Site Audit conducted on 10 to 12 March 2021 in relation to Requirement (3)(e) as the service was unable to demonstrate appropriate referrals to individuals, other organisations, community associations and providers of other care and services.

At this Assessment Contact the Assessment Team recommended Requirement (3) (e) as met. The Approved Provider submitted a response in relation to the Assessment Team’s report and based on the information before me I find the service Compliant in this Requirement. My reasons are outlined below.

An overall rating of the Standard has not been provided as only one of the Requirements were assessed.

## Assessment of Standard 4 Requirements

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

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

The Assessment Team found the service was able to demonstrate there were timely and appropriate referrals to individuals, other organisations and providers. The Assessment Team provided information and evidence relevant to my findings:

* Overall sampled consumers considered they received the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they want to do. Feedback included, Consumers sampled expressed their gratitude to lifestyle and care staff and stated they enjoy attending the activities provided inside and outside the service. Consumers said all staff support them to continue in participating with their community connections and to maintain their needs, including attending individual service providers, community associations, church services, bus outings and the hairdresser service.
* The service had implemented several actions in relation to the identified Non-Compliance which included:
  + Development of a referral (non-clinical) menu/register folder for individuals, other organisations, community associations and providers of other care and services for consumers residing at the service. Staff, consumers and their representatives were aware of the referral folder located in the reception area.
  + A new Lifestyle Coordinator had been appointed and all consumer’s care plans re-assessed for lifestyle and leisure preferences, needs and goals.
* The Assessment Team noted the service’s planning and assessment processes were in place to ensure consumers’ lifestyle and leisure activities included engagement, connections and networks with individuals, community associations and links to external services.
* Care plans sampled included detailed individualised personal and clinical care management strategies based on assessed needs and consultation with consumers and/or representatives, inclusive of other organisations who provide consumer services.
* Lifestyle staff described how they have sourced external organisations and put in place an external referral menu/register which is continuously updated to supplement the lifestyle activities offered within the service.
* Care and lifestyle staff were able to describe the policies, procedures, and practices for referral to individual providers outside the service and informed the Assessment Team which consumers leave the service for community connections. Staff said they were notified of changes to consumers’ care and service needs through handover, alerts, progress notes and meetings.
* Management outlined additional supports that were currently being considered in relation to accessing volunteers through the Community Visitors Scheme and linking in with a new formed café group run by the church.

Based on the information before me, I find the service Compliant in this Requirement.

# STANDARD 7 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

This Standard was found Non-Compliant following a Site Audit conducted on 10 to 12 March 2021 in relation to Requirement (3)(c) as the service was unable to demonstrate staff were competent in the management of consumers’ care needs specifically in the management of pain, behaviours, wounds, weight and diabetes and staff were not aware of their responsibilities in relation to reportable assault incidents.

At this Assessment Contact, the Assessment Team recommended Requirement (3) (c) as met. The Approved Provider submitted a response in relation to the Assessment Team’s report. Based on the information before me, I find the service Compliant in this Requirement. My reasons are outlined below.

An overall rating of the Standard has not been provided as only one of the Requirements were assessed.

## Assessment of Standard 7 Requirements

### 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.*

The Assessment Team found the service was able to demonstrate the workforce was competent and had the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following information and evidence relevant to my findings:

* Overall sampled consumers considered they received quality care and services when they needed them and from people who were knowledgeable, capable, and caring. Consumers and representatives also confirmed they felt staff were competent.
* The service had an induction/onboarding process to ensure new clinical, care and services staff were supported, supervised and competent to complete their role.
* The service ensured all care and nursing staff provided their qualification and current registration to the service annually, this was monitored by management.
* Staff were allocated training based on their roles and management monitored staff completion rates for mandatory training to ensure all staff complete their allocated training. Online training was available to staff which covered clinical related topics for consumer high impact risks and behaviours.
* Resource folders, guidelines and pamphlets were readily available to staff explaining infection control, transmission of infections, wound and skin integrity care as well as behaviour management.
* Staff said they felt confident to perform their role, were supported by management and were provided regular mandatory and awareness training opportunities. Care and nursing staff confirmed they had received training in a range of topics and regularly undergo competency assessments in drug calculations, medication, and catheterisation management.
* An annual performance appraisal process was in place for all staff and the service had implemented a number of improvements in response to the Non-Compliance including staff training for pain, behaviour, weight and diabetes management as well as other areas such as the serious incident scheme and infection control and antimicrobial stewardship. Other improvements implemented included:
  + An electronic training program implemented and rolled out September 2021.
  + Two of the service’s managers have attended Infection Control Program training and were now certified Infection Control Leads for the service.
  + Antimicrobial stewardship flyers and training resources displayed and distributed for staff. Antimicrobial stewardship, continence, catheter, pain, weight loss, nutrition and Serious Incident Response Scheme reporting were added to clinical and care staff annual competencies.
  + The service’s clinical policies, procedures and protocols were updated to reflect changes in relation to weight loss, resident of the day, wound assessment, cytotoxic drugs and waste as well as topical antimicrobials and specimen collection.

I note training in respects to changes in restrictive practices/behaviour support plans had not occurred and at the time annual competencies were overdue and had not been completed. While I have considered behaviour support plans/restrictive practice training in relation to Standard 8, I acknowledged the Approved Provider had advised annual competencies and education in behaviour support plans/restrictive practices had since been completed.

Therefore, based on the information before me, I find the service Compliant in this Requirement.

# STANDARD 8 NON-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

This Standard was found Non-Compliant following a Site Audit conducted on 10 to 12 March 2021 for Requirements (3) (c) and (3) (e) as the service was not able to demonstrate effective clinical and organisational wide governance systems were in place.

At this Assessment Contact, the Assessment Team recommended Requirement (3) (e) as Not met and (3) (c) as Met. The Approved Provider submitted a response in relation to the Assessment Team’s report. However, based on the information before me, I have come to a different view to that of the Assessment Team and I find the service Non-compliant in (3) (c) and (3) (e). My reasons are outlined below.

The Quality Standard is assessed as Non-Compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-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 Assessment Team found the organisation was able to demonstrate effective governance systems in relation to information management, workforce governance, financial governance, feedback and complaints, however I have come to a different view and find the service Non-Compliant in this Requirement. I have included the reasons for my decision below.

In relation to information management systems

* The service generally demonstrated there was an effective information management system to support delivery of care and services. The Assessment Team did note some areas of inconsistencies in relation to the management of medical officer information and communication of information to representatives. Furthermore, I note the Approved Provider’s response had address these and provided further clarifying information regarding its process for recording medical officer notes.
* However, I do note that not all processes for the management of information have been effective. For example, not all policies and procedures were up to date, (specifically in relation to restrictive practices and behaviour support plans) and staff recording of incident reports to support further investigation and actions. I have however, considered this information more relevant in relation to regulatory compliance and clinical governance and therefore overall consider there were overall effective information management systems in place.

In relation to continuous improvement

* The Assessment Team noted that management was able demonstrate how it monitored and used feedback from consumers, staff, representatives, and others in driving improvements. A priority action workplan was in place which demonstrated a range of improvement initiatives and although the plan did not always include responsible officers, dates for completion or an evaluation, the Assessment Team reported most items included monitoring and review.
* I also acknowledge the ongoing improvements activities completed in respects to the areas of Non-Compliance from the Site Audit in March 2021 with four Requirements now Compliant. In relation to the three Non-Compliant Requirements, the Approved Provider had submitted a plan for continuous improvement to address these deficiencies and had also provided additional evidence of actions completed following the Assessment Contact. I do however remain concerned regarding the service’s processes for the ongoing monitoring and identifying deficiencies in its systems.

In relation to workforce governance

* Senior management outlined the recruitment strategies being employed at the service and the Assessment Team noted there were systems in place to ensure staff were onboarded, appropriate checks undertaken, and the performance of staff monitored. Furthermore, the service had implemented a range of actions in relation to Standard 7 (3) (c) including additional training and support for staff, and certification of two infection control leads. Consumers and representatives provided positive feedback in relation to staff competence, provision of care and services and staff confirmed support in place to undertake their roles.

In relation to regulatory compliance

* In response to the previous areas of Non-Compliance relating to ensuring compliance with compulsory reporting requirements, the service had implemented the following actions:
  + Provided education about the Serious Incident Response Scheme (SIRS) to all nursing staff and had scheduled this as part of annual competencies.
  + Attendance of the SIRS webinar by senior clinical staff.
  + Selection of staff had signed to acknowledge they had read the new legislation.
  + Development of SIRS policy and resources, with information sent to entire team and discussed with the team at staff meeting.
  + SIRS reporting added into the electronic care plan system.
  + The service was able to demonstrate use of SIRS reporting through the incident management system.
* While processes were implemented to ensure compliance with SIRs related requirements, I am concerned the organisation’s governance systems were not effective in responding to legislative changes. The Assessment Team identified although management demonstrated an awareness of the legislative changes relating to use of restrictive practices, the service had not introduced an updated policy in relation to restrictive practices following the 1 July 2021 changes and subsequently had not implemented behaviour support plans that covered the required aspects of the legislation as, required by 1 September 2021.
* The Assessment Team noted a number of consumers where restrictive practices were in place had not been identified/assessed, behaviour support plans and policies available were not consistently reflective of legislative requirements and staff education had not occurred (as outlined in Standard 8 Requirement (3) (e)).

In relation to financial governance and feedback and complaints

* I acknowledge the Approved Provider has organisational wide governance systems for financial governance and feedback and complaints.

The Approved Provider’s response outlined the action taken in relation to implementation of new policies, education for staff in restrictive practices, completion of behaviour support plans and completion of a follow up audit. While I acknowledge actions taken, at the time of the Assessment Contact, the organisation was not able to demonstrate it consistently had effective organisational governance systems in place. Therefore, based on the information before me, I find that this Requirement is Non-Compliant.

### Requirement 8(3)(e) Non-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 Assessment Team identified the service had implemented improvement actions in relation to its clinical governance framework such as completion of monthly audits, analysis and trending of incidents and improved use of the electronic care system.

However, the service was not able to demonstrate it had an effective clinical governance framework in relation minimising the use of restraint. The Assessment Team provided the following information and evidence relevant to my finding:

* The organisation had not sufficiently identified, updated and implemented its framework in relation to minimising restraint. The Assessment Team noted changes to restrictive practice requirements including policies and procedures and the use of behavioural support plans were not implemented or consistently reflective of current requirements. Furthermore, there had not been education or communication provided to staff in order to support their awareness or implementation of these.
* The service had also reviewed behaviour care plans and considered the current plans to be adequate to meet the new requirements. However, the Assessment Team viewed a sample of behaviour care plans and found they did not consistently align with the behaviour support plans, requiring the identification and inclusion of assessment of the behaviour of concern, known triggers, alternative strategies, use of restrictive practices and consent.
* The service had not identified all consumers impacted by a restrictive practice (chemical and/or environmental).
  + Consumers in both secured areas of the service (32 consumers) had not been identified as being impacted by a restrictive practice (environment) and did not have relevant authorisation completed.
  + Although the service identified individual and overarching trends for the use of psychotropic medications, six consumers had been noted as being prescribed medications for anxiety/agitation that were not identified by the service as a chemical restraint.
* The Assessment Team also noted not all incidents relating to consumer physical aggression had been reported as an incident report to support an investigation, follow up and review of effective/ineffective behaviour management strategies.

The Approved Provider’s response did not refute the Assessment Team’s findings and acknowledged the deficits through the submission of a plan for continuous improvement outlining how the service had addressed the gaps. This included updating of policies, education for staff, completion of an audit and information provided to consumers and representatives. Furthermore, its submission also included care documentation for 35 consumers relating to restrictive practice authorisation forms (mechanical, environmental and chemical) and their respective behaviour support plans.

I acknowledge extensive improvements made in order to address the deficiencies in the organisational clinical governance framework. However, at the time of the Assessment Contact the organisation was not able to demonstrate all aspects of the framework were implemented to effectively support the ongoing quality and safe of care for consumers. I am concerned that there were a large number of consumers where a restrictive practice was in place where the identification, authorisation and appropriate behaviour support plans had not been in place.

Therefore, based on the information below me, I find the Service Non-Compliance in this Requirement.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 3 Requirements (3)(a)**

* Ensure the service consistently implements best practice guidelines for the use of restrictive practices and behaviour support plans to support safe and effective care.
* Ensure consumers’ behaviour management strategies continue to be tailored and reviewed in response to incidents.
* Ensure consumers’ wellbeing is monitored where a restrictive practice is implemented, and that appropriate assessment and care planning is completed.

**Standard 8 Requirements (3)(c) and (3)(e)**

* Ensure there are effective governance systems implemented to support the identification and ongoing compliance with changes in legislative requirements.
* Ensure the organisation’s clinical governance framework is effective, supports the ongoing management and minimisation of restrictive practices as well as supports the safe and effective delivery of care and outcomes for consumers.