Performance

Report

**1800 951 822**

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| Name of service: | ACH Group Residential Care - Highercombe |
| Service address: | 5-11 Sirius Avenue Hope Valley SA 5090 |
| Commission ID: | 6289 |
| Approved provider: | Aged Care & Housing Group Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 6 September 2022 |
| Performance report date: | 3 November 2022 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for ACH Group Residential Care - Highercombe (**the service**) has been prepared by Janine Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the Assessment Team’s report received on 26 September 2022; and
* the performance report dated 23 February 2022 for the Site Audit undertaken from 15 December 2021 to 17 December 2021.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

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

**Standard 3 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to identify chemical restraint, ensure tailored non-pharmacological strategies are used prior to administration of psychotropic medication and ensure Behaviour support plans are in place as per regulatory requirements.

**Standard 4 Requirement (3)(f)**

* Ensure meals are of sufficient quality and variety.
* Ensure consumer involvement in planning and evaluation of the menu, and seek regular feedback from consumers in relation to food satisfaction.

**Standard 6 Requirement (3)(c)**

* Ensure complaints from all sources are recorded on the complaints register to ensure appropriate actions occur, trends are identified and areas for improvement in care and services are identified.
* Ensure a timelier response to complaints.

**Standard 8 Requirement (3)(c)**

* Review the organisation’s governance systems in relation to regulatory compliance and feedback and complaints.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service did not demonstrate risk assessments were completed for consumers who leave independently and use tricycles.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, review of all consumers undertaking risky activities to ensure risk assessments had been completed and consent was obtained, implemented monitoring processes and provided staff education and training.

At the Assessment Contact undertaken on 6 September 2022, the Assessment Team found the service supports consumers to take risks to enable them to live the best life they can. Consumers said they are supported to take risks and provided examples of mitigation strategies implemented to ensure their safety. Risk assessment processes are in place and include input from representatives and allied health professionals to support consumers and minimise risks. Care planning documentation documented consumers’ activities of interest, any associated risk and mitigation strategies.

The provider did not respond to the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirements (3)(a) and (3)(g) were found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service did not demonstrate:

* each consumer received safe and effective care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to chemical restraint and timeliness of pain medication; and
* minimisation of infection related risks, specifically in relation to inadequate visitor/staff screening and check-in procedures, non-functional hand sanitising units and lack of an infection prevention and control (IPC) lead.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

In relation to Requirement (3)(a):

* implemented processes to ensure all relevant clinical policies and procedures have been read by staff and are discussed at clinical meetings;
* scheduled and/or completed staff education and training in relation to pain monitoring tools, diabetes management, changing behaviours, restrictive practices, and high impact or high prevalence risks;
* commenced a telehealth pilot to improve access to Medical officers;
* reviewed and updated policies and procedures in relation to restrictive practices; and
* implemented improvements to manage changing behaviours, including creation of a dedicated area to support consumers with a diagnosis of dementia or cognitive impairment and establishing a behavioural support team.

In relation to Requirement (3)(g):

* updated duty statements and scheduled audits to ensure functionality of hand sanitiser units are monitored;
* implemented a TGA-approved integrated entry management system for visitor screening;
* engaged an IPC mentor to provide education and training to two staff enrolled in an IPC lead course;
* updated the Outbreak management plan;
* installed additional hand sanitising units throughout the environment; and
* completed audits in relation to infection control and hand hygiene.

At the Assessment Contact undertaken on 6 September 2022, the Assessment Team recommended the service does not meet Requirement (3)(a), as they were not satisfied the service demonstrated consumers get safe and effective care that is best practice, tailored to their needs and optimises their health and well-being. Specifically, the Assessment Team found the service did not demonstrate an understanding of restrictive practices or that restraint authorisation was obtained in line with legislative requirements. The Assessment Team did however, recommend the service meets Requirement (3)(g), as they were satisfied improvements implemented as a result of the previous non-compliance were effective and found the service demonstrated effective minimisation of infection related risks. The Assessment Team provided the following evidence relevant to my finding:

In relation to Requirement (3)(a):

* During the entry meeting, management said only one consumer was subject to chemical restraint, however, the Assessment Team noted seven consumers had been prescribed psychotropic medication for anxiety and/or insomnia. The service was unable to demonstrate these medications had been reviewed to identify if they were being administered to manage consumers’ changed behaviours and as a form of chemical restraint.
* Documentation and interviews with staff showed chemical restraint was not administered to one consumer as minimally as possible and as a last resort, and the consumer did not have a Behaviour support plan to guide care delivery. For example:
  + Progress notes did not demonstrate that non-pharmacological interventions were trialled prior to administering chemical restraint.
  + Five staff were unable to describe non-pharmacological measures trialled for this consumer to manage their changed behaviours.
  + For a 37-day sampled period, the consumer was administered a benzodiazepine on 34 occasions for insomnia, however, the most recent sleep assessment shows the consumer had no disruption to sleep.
  + Behaviour charting identified changed behaviours and staff documented reassurance was provided with no effect, however, no further actions were documented.
  + A Behaviour support plan was commenced, however, was not completed or provided to the Assessment Team.

The provider does not agree with the Assessment Team’s findings in relation to Requirement (3)(a). Their response includes information, which the provider asserts was presented to the Assessment Team at the Assessment Contact but was not reflected in the totality of evidence in the Assessment Team’s report. This includes:

* Anxiolytic medications are reviewed by a General practitioner every three months, which includes completion of authorisations, open disclosure to explain side effects and obtaining informed consent.
* Behaviour support plans list identified non-pharmacological strategies to manage changed behaviours.
* All consumers who are prescribed anxiolytics have had a full review in the last six months, with only three having had medication administered.
* There are well documented progress notes to show non-pharmacological interventions have been used.

The provider’s response also includes actions taken and/or planned to address deficits identified by the Assessment Team, which include, but are not limited to, undertaking an audit of restrictive practices documentation, staff training and education, commencement of monthly meetings for the Care manager and Clinical nurse, family meetings to discuss medications, and General practitioner review of some consumers’ medications. I acknowledge actions taken by the provider to address identified issues.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate each consumer received safe and effective care that was best practice, tailored to their needs and optimised their health and well-being.

I have considered that the service did not review psychotropic medication administered to seven consumers to determine whether their use falls within the definition of chemical restraint*.* As a result, the service failed to meet their regulatory obligations under the *Quality of Care Principles 2014*, as one consumer did not have a Behaviour support plan to guide staff in safe and effective care delivery, and chemical restraint was not used minimally and as a last resort. The provider’s response includes additional information to refute evidence in the Assessment Team’s report, however, the response did not include any evidence to support their assertions.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

In relation to Requirement (3)(g):

* Consumers and representatives were satisfied with communication and care provided throughout the previous coronavirus (COVID-19) outbreak, as they were told what was happening, staff were wearing appropriate personal protective equipment (PPE) and practicing hand hygiene, and consumers were regularly monitored.
* Staff confirmed they have completed training in relation to hand hygiene, COVID-19, and donning and doffing of PPE. Staff also confirmed sufficient stock was available and they felt supported during previous COVID-19 outbreaks.
* PPE stations were observed set up at entry points and hand washing stations and sanitisers were accessible in communal areas. Staff were observed washing hands between consumers and wearing PPE correctly.
* Management provided examples of improvements that have been made to the service’s Outbreak management plan as a result of learnings from previous outbreaks.
* Infections are monitored through monthly trending and actions are taken in response. Antimicrobial stewardship is monitored and discussed at monthly meetings.

The provider did not respond to the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |

Findings

Requirement (3)(f) was found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service did not demonstrate meals were of suitable quality and variety.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing education to kitchen staff in relation to the dining experience, completed a meal audit of serving sizes, and approval has been received to install new ovens to improve food reheating.

At the Assessment Contact undertaken on 6 September 2022, the Assessment Team was not satisfied the service demonstrated food was of suitable quality and quantity. The Assessment Team provided the following evidence relevant to my finding:

* Six of 10 consumers and representatives expressed dissatisfaction with the quality and quantity of food provided to consumers. Consumers said meals lack taste, portion sizes are too large, food was predominately overcooked, there is not a lot of variety and the food can be difficult to chew. One of the six consumers said they do not bother providing feedback as nothing changes and another said they provided feedback at a consumer meeting, but nothing was done about it.
* Staff said meals are cooked at a central kitchen and are then chilled, delivered to site and reheated prior to consumption. Staff confirmed consumers are generally offered alternative meals if they do not like what is offered, and any complaints received are forwarded to the head chef.
* The menu includes both hot and cold selections, has been reviewed by a Dietitian and is changed twice per year. Consumers who did not like the meals on the menu were observed to be offered other options.
* Head office generates a trend report based on data from the service’s feedback register. However, the service’s feedback register did not include feedback provided by consumers at Resident council meetings and focus groups.
* Food surveys were completed in July 2022, however, only eight consumers were sampled.

The provider does not agree with the Assessment Team’s findings. Their response includes information, which the provider asserts was presented to the Assessment Team at the Assessment Contact but was not reflected in the totality of evidence in the Assessment Team’s report. This includes:

* The project for installation of four ovens was delayed due to global market shortfalls but is planned for commencement on 14 October 2022. As part of this process, two kitchens will be remodelled to allow more food to be cooked on site.
* The meal audit on serving sizes found the portions served were correct to meet daily nutritional requirements of consumers.
* Processes have been implemented to ensure chefs from the production kitchen will work at the service on a regular scheduled basis to assess food quality and consumer satisfaction.
* In relation to the consumers who provided negative feedback to the Assessment Team regarding the food:
  + Management meet with one consumer regularly to discuss their food preferences and the consumer is pleased with the outcome of these meetings. The consumer attends the service’s food focus group and is encouraged to provide feedback. The consumer is provided with condiments to assist with enhancing the flavour of their meals and additional herbs and spices have been purchased to adapt meals to their preferred taste.
  + The service has not received any complaints from the consumer who reported they provided feedback, but nothing gets done. Resident council meeting minutes were provided to show they once asked for clarification on what fillings were in the sandwiches. While the provider claims this matter was resolved, evidence of this was provided.
  + The consumer who said meals are overcooked and difficult to chew is aware of plans to improve reheating of meals. The service has followed up with the consumer, who said they were satisfied with the food.
  + The service has met with one consumer who said food can be tough and they were not happy with meals. The consumer said they were happy with everything and had no issues with the food.
  + One consumer who said they have toast too often has a moderate cognitive impairment and associated short-term memory loss. They are provided with toast/toasted sandwich for dinner on request as the consumer often refuses alternatives offered.
* All feedback and follow-up from Resident meetings has been logged on the feedback register.
* Food satisfaction surveys are conducted four times per year, however, collection of survey responses has been hampered by COVID-19, as head office and quality team staff have been unable to attend site to conduct surveys.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate meals were of suitable quality and variety.

I have considered that six of 10 consumers and representatives expressed dissatisfaction with the quality and quantity of food provided to consumers, due to lack of variety and taste, and being overcooked and difficult to chew. While the provider’s response includes information to provide context and/or refute these consumer and representative statements, no evidence was provided to support their assertions. I acknowledge that some action has been taken and/or planned to ensure improvement in the quality of meals, however, processes in place are not effective in obtaining consumer satisfaction and feedback in relation to the quality and variety of meals. The feedback register, which is used to drive improvement, does not include feedback from all sources to enable accurate trending and analysis of food complaints, satisfaction and feedback. Additionally, the last food survey only sampled eight consumers. While the provider’s response states that relevant staff were unable to attend site to conduct surveys due to COVID-19, other methods of surveying consumers were not utilised to ensure a suitable sample size.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(f) in Standard 4 Services and supports for daily living.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirements (3)(c) and (3)(d) were found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service did not demonstrate:

* appropriate action was taken in response to complaints and an open disclosure process was used when things go wrong; and
* feedback and complaints were reviewed and used to improve the quality of care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

In relation to Requirement (3)(c):

* actioned and closed all complaints; and
* added a standing item about complaints processes and continuous improvement to resident newsletter.

In relation to Requirement (3)(d):

* added feedback, suggestions, complaints and compliments as a standing agenda item for Resident council meetings;
* newsletter included apology provided to consumers in relation to delays in actioning complaints; and
* management is evaluating on-site improvements to capture all feedback to ensure trends are accurate.

At the Assessment Contact undertaken on 6 September 2022, the Assessment Team recommended the service does not meet Requirement (3)(c), as they were not satisfied the service demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The Assessment Team did, however, recommend the service meets Requirement (3)(d), as they were satisfied improvements implemented as a result of the previous non-compliance were effective and found the service demonstrated feedback and complaints are reviewed and used to improve the quality of care and services.

In relation to Requirement (3)(c):

* One representative said they had complained to clinical staff regarding an incident where staff told the consumer to stop ringing the call bell as they had other consumers to attend to. Staff told the representative the matter was investigated, and it was determined that agency staff were responsible for the incident. The representative said the consumer is a high falls risk and was concerned they would attempt to toilet themselves as they are scared to press the call bell for assistance.
  + Staff confirmed the incident occurred approximately two months ago, that discussions with the consumer’s family were ongoing and a toileting schedule was in place.
  + Management said they were unaware of the complaint and incident.
  + The complaint was not documented on the register and evidence was not provided demonstrating the incident was investigated.
* Six of 10 consumers sampled reported ongoing dissatisfaction with food quality, with three of the six consumers reporting ‘giving up’ in providing feedback because nothing changes.
* Feedback from the food focus group in March 2022 and consumer survey in July 2022 for eight consumers was not documented in the feedback register.
* Head office generates a trend report based on data from the service’s feedback register. However, the service’s feedback register did not include all feedback provided by consumers and/or representatives. The feedback register did not include any feedback provided at Resident council meetings and focus groups.
* A monthly feedback report generated by head office to the service was requested but not provided to the Assessment Team.

The provider does not agree with the Assessment Team’s findings in relation to Requirement (3)(c). Their response includes the following information and evidence to refute the Assessment Team’s assertions:

* A statement indicating that any complaints raised to management are followed up promptly and feedback is provided to the complainant.
* An explanation that the incident regarding the consumer who was told to stop ringing their call bell was not reported to management and the complaint was resolved to the consumer and families’ satisfaction. The complainant has been contacted and said they had not made a complaint and they were happy with the care provided. A call bell report was provided demonstrating the consumer pressed their call bell on 15 occasions during the night.
* In relation to the six consumers’ ongoing dissatisfaction with food, all matters raised via the various feedback mechanisms have been resolved.
* A Feedback trend report was provided to demonstrate how feedback and complaints are collated and analysed.

The provider’s response also includes actions taken and/or planned to address deficits identified by the Assessment Team, which include, but are not limited to, staff education and training, and held case conferences with affected families of consumers. I acknowledge actions taken by the provider to address identified issues.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

In relation to the complaint regarding the consumer who was told not to use their call bell, I have considered that complaints processes were not effective in ensuring the complaint was documented, investigated and resolved appropriately. While staff said discussions with the consumer’s family were ongoing and the provider’s response states the complaint had been resolved, no evidence was provided to support this occurred. I acknowledge the provider’s view that this one example in isolation is not indicative of systemic failure in the organisation’s complaints handling processes, however, I have also considered that six of 10 consumers and representatives were dissatisfied with the quality and quantity of food provided to consumers, with three of the six consumers reporting ‘giving up’ in providing feedback because nothing changes.

I have also considered that the feedback register does not include feedback and complaints from all sources to enable accurate monitoring of action taken. I have considered the monthly feedback report included in the provider’s response and note areas for improvement in the timeframes which complaints are acknowledged, which is 44.8 days.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

In relation to Requirement (3)(d):

* Management provided examples of how feedback and complaints have been used to improve care and services, including moving consumers who have dementia related behaviours to one area of the service to ensure better care is provided and to minimise impact to other consumers, and initiating referrals to counselling services for consumers.
* Upgrades to kitchens and appliances have been planned as a result of feedback from food focus groups.

The provider did not respond to the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service did not demonstrate staffing numbers were sufficient to enable the delivery and management of safe and quality care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, undertaking recruitment, implementation of a new workforce model, improvements to workforce reporting and analysis, undertaking daily call bell monitoring and investigation, and providing staff training and education.

At the Assessment Contact undertaken on 6 September 2022, the Assessment Team found the service demonstrated 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. Consumers acknowledged there can be staff shortages at times, however, said it does not impact on their care delivery and staff are quick to respond to their call bells. Staff confirmed most unplanned absences are generally filled. Management said there has been a reduction in unfilled shifts due to recruitment of additional staff and improvements to the rostering system has created more efficiencies and options to fill unplanned leave.

The provider did not respond to the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(a) in Standard 7 Human resources.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |

Findings

Requirement (3)(c) was found non-compliant following a Site Audit undertaken from 15 December 2021 to 17 September 2021, where it was found the service’s organisation wide governance systems were not effective in relation to regulatory compliance and feedback and complaints. Specifically, the service was not effectively assessing, monitoring and minimising the use of restraint in line with their regulatory obligations, and all feedback and complaints were not being recorded and resolved in a timely manner.

The Assessment Team’s report for the Assessment Contact undertaken on 6 September 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the organisation’s governance systems relating to regulatory compliance and feedback and complaints were ineffective. The Assessment Team provided the following evidence relevant to my finding:

* The organisation’s monitoring and review process for overseeing restrictive practices includes an internal behaviour support team, procedures and flow charts, internal care file reviews and a restrictive practices champion.
* The service has systems and processes in place, such as subscribing to various services that provide regulatory updates, a central quality team to perform audits, Behavioural support plans, policies and procedures, and education/training. However, as demonstrated in Requirement (3)(a) in Standard 3 Personal care and clinical care, the organisation did not ensure its regulatory obligations were met in relation to consumers subject to restraint.
* One representative said they lodged a complaint in relation to an incident that occurred. While staff said the incident had been investigated, it was not recorded as an incident, reported under the Serious Incident Response Scheme (SIRS) or included in the service’s feedback or complaints register.
* The service has systems, policies and procedures for complaints handling, however, feedback provided by consumers is not always centrally documented in the complaints system and monthly trending undertaken by head office is based on information captured in this register.
* The service was unable to demonstrate all feedback was documented or followed up in a timely manner.
* Information is communicated across the service via multiple channels, including newsletters, emails, handover, meetings and training, and policies and procedures are accessible to all staff.
* The service maintains a Plan for continuous improvement, which is informed from feedback and complaints, surveys, focus groups and audits.
* The service has processes to support the reporting of financial expenditure which includes involvement from the Site manager.
* Governance systems are in place to manage workforce numbers, monitor staff performance and competency to ensure the safety and quality of care provided.

The provider does not agree with the Assessment Team’s findings. Their response includes the following information and evidence to refute the Assessment Team’s assertions:

* Anxiolytic medications are reviewed by a General practitioner every three months, which includes completion of authorisations, open disclosure to explain side effects and obtaining informed consent.
* Behaviour support plans list identified non-pharmacological strategies to manage changed behaviours.
* All consumers who are prescribed anxiolytics have had a full review in the last six months, with only three having had medication administered.
* There are well documented progress notes to show non-pharmacological interventions have been used.
* The incident was reported to the Clinical nurse who worked with the family to follow up on the complaint and resolve their concerns. An apology has been provided to the consumer and their representatives have been advised of ongoing follow up.

The provider’s response also includes actions taken and/or planned to address deficits identified by the Assessment Team, which include, but are not limited to staff education and training, submitted required SIRS reports, added feedback and complaints to meeting agendas and completed review of processes relating to restrictive practices.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate the organisation’s governing systems were effective in relation to regulatory compliance and feedback and complaints.

I have considered that the service did demonstrate and understanding of its regulatory obligations under the SIRS, as one reportable incident was not reported to the Commission.

Additionally, the service did not demonstrate an understanding of legislation in relation to restrictive practices. Evidence in the Assessment Team’s report under Requirement (3)(a) in Standard 3 Personal care and clinical care showed psychotropic medication administered to seven consumers was not reviewed to determine whether it was a restraint, one consumer did not have a Behaviour support plan, and chemical restraint was not used minimally and as a last resort. I have considered that the provider’s response included additional information to refute evidence in the Assessment Team’s report, however, no evidence was provided to support their assertions.

Furthermore, the service failed to demonstrate effective governance systems in relation to feedback and complaints, as all feedback and complaints are not logged in the register to enable monitoring of complaints resolution and effectively trend and analyse complaints to identify areas for improvement.

I have also considered that the deficits identified at the Assessment Contact undertaken on 6 September 2022 are of a similar nature of those identified at the Site Audit undertaken from 15 December 2021 to 17 December 2021.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)