Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Adventist Residential Care |
| Service address: | 31 Webb Street ROSSMOYNE WA 6148 |
| Commission ID: | 7852 |
| Approved provider: | Seventh-day Adventist Care (Western Australia) Ltd |
| Activity type: | Site Audit |
| Activity date: | 7 March 2023 to 9 March 2023 |
| Performance report date: | 20 April 2023 |

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

**This performance report**

This performance report for Adventist Residential Care (**the service**) has been prepared by M Glenn, 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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* the provider’s response to the Assessment Team’s report received 31 March 2023.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **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 2 requirement (3)(b)**

* Ensure care plans are reflective of consumers’ current and assessed needs and preferences and appropriate management strategies developed and implemented to enable staff to provide quality care and services.
* Where consumers’ are subject to restrictive practices, ensure appropriate consents and authorisations are documented, management strategies are developed and Behaviour support plans include all required information in line with legislative requirements.

**Standard 3 requirement (3)(b)**

* Ensure staff have the skills and knowledge to:
* support consumers and/or representatives to understand the risks and make an informed decision in relation to use of chemical restraint, including where changes to medications occur; and
* implement alternative, non-pharmacological strategies prior to administration of chemical restraint, monitor consumers and the effectiveness of chemical restraint following administration, and use restrictive practices in line with legislative requirements, including as a last resort.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, specifically use of restrictive practices are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, specifically use of restrictive practices.

**Standard 8 requirement (3)(e)**

* Review the organisation’s clinical governance framework, specifically in relation to minimising use of restrictive practices.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | 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. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | 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. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Assessment Team recommended all six requirements in Standard 1 Consumer dignity and choice met and provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Consumers sampled said they are treated with dignity and respect and felt staff knew what was important to them as an individual. Representatives said staff are always respectful, know their loved ones very well and provide the care and support they need. Staff described how they treat consumers with respect by using their preferred name and ensuring care is delivered that considers consumers’ choice and preferences. Staff interactions with consumers were observed to be kind and respectful.

Care files sampled demonstrated consumers’ cultural identity is considered and this informs how they deliver culturally safe care and services. Consumers’ cultural safety needs are assessed on entry and on an ongoing basis. Care files sampled included consumers’ specific cultural and religious needs, such as individual interests, customs, beliefs, cultural and ethnic backgrounds and this information is used to inform delivery of care and services. Staff demonstrated familiarity of consumers and an understanding of their backgrounds and care preferences. Consumers said they receive care and services that are right for them, indicating staff know and understand their beliefs and values and are respectful of these.

Consumers sampled were satisfied they are supported to make or be involved in decisions about their care and services, make connections and maintain relationships of choice, including intimate relationships. Consumers are asked on entry who they would like involved in their care and decision making and this is documented in consumer care files. Staff provided examples of how they support consumers to exercise choice and independence, including by setting their own routine and preferences for care.

There are processes to support consumers to take risks to enable them to live the best life they can. Where consumers choose to undertake an activity which includes an element of risk, assessments are completed in consultation with consumers and/or representatives, and safeguards are implemented to mitigate risks, where possible. Allied health professionals are also involved in the assessment process, where required. Clinical staff said assessment and consideration is given to consumers’ level of ability and cognition to participate and promote independence, and risk-taking activities are considered a valuable part of independence.

Consumers were satisfied information provided to them is accurate, up-to-date and provided in a timely manner. Information is provided to consumers through a range of avenues, including face-to-face, emails, noticeboards, meeting forums and newsletters. Staff described how they ensure consumers understand information, including through the use of cue cards and language folders which enable them to communicate more effectively with consumers who have English as a second language. There are processes to ensure consumers’ privacy is respected and personal information is kept confidential.

Based on the Assessment Team’s report, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | 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. | Non-compliant |
| Requirement 2(3)(c) | 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. | Compliant |
| Requirement 2(3)(d) | 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. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(b)**

Consumers and representatives confirmed they are provided opportunities to discuss consumers’ current needs, including end of life planning on entry, annually or when care needs or preferences change. A terminal diagnosis or deterioration in health prompts a proactive, holistic multidisciplinary approach where care and service plans are reviewed, and end of life care plans created that support consumers’ needs and preferences. However, the Assessment Team were not satisfied care files included information to demonstrate an effective process for ensuring consumers’ current needs, goals and preferences are captured in care and service plans. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Five care staff demonstrated how they access and use the electronic summary care and service plans when looking for information related to consumer care.
* Information in Consumer A’s Transfer and mobility care plan was not consistent with the consumer’s current needs or the information documented on a whiteboard relating to these needs located in the consumer’s room. Four care staff were familiar with the consumer’s current transfer and mobility needs.
* Consumer B’s care and service plan does not include the consumer’s diagnosis of diabetes or any information related to needs, goals or management strategies to guide staff in the related delivery of care. Clinical staff reported the consumer’s diabetes management had been complex and blood glucose levels unstable and had required specialist involvement to help manage the condition. The care file did, however, demonstrate blood glucose level monitoring and insulin administration had been undertaken as prescribed.
* While care staff were familiar with Consumer B’s specialised nursing care needs, the care and service plan did not include information related to this care need or goals and strategies to direct staff in delivering care.
* Ten Behaviour support plans did not indicate the consumers were subject to chemical restrictive practice or include monitoring or individualised strategies to trial prior to administration of psychotropic medication. Three staff reported they did not use Behaviour management plans or know where they were located.
* Lifestyle information was not detailed eight care and service plans sampled, nor did they include activities and consumer preferences.

The provider’s response consisted of a Plan for continuous improvement (PCI) directly addressing the issues identified in the Assessment Team’s report, as well as supporting documentation. Information included in the response and/or actions initiated and/or planned include, but are not limited to:

* During the last software update for the electronic care system, form mapping was disrupted. Affected forms have been mapped and all forms are now under a review cycle post the software upgrades.
* Consumer A’s Mobility assessment and Transfer and mobility care plan has been updated to reflect current needs.
* A Diabetes assessment form has been implemented for Consumer B and a care plan developed outlining management strategies relating to technical nursing care, inclusive of diabetes and the specialised nursing care need.
* Updated Behaviour support plans to include restrictive practice risks. The provider’s response included a Behaviour management plan, Restrictive practice authorisation form and Negotiated risk form for one consumer.
* Reviewed and amended the Restrictive practice policy to reflect best practice.
* All activity plans have been saved to the new format and reviewed to reflect consumers’ current needs.

I acknowledge the provider’s response. However, this requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences. As such, I find the service did not demonstrate assessment and planning identified and addressed consumers’ current needs, goals and preferences.

In coming to my finding, I have considered care plans for Consumers A and B were not congruent with current care needs. I acknowledge staff sampled were knowledgeable of Consumer A and B’s current care needs, and described care provision related to these aspects of care. However, feedback indicated staff access electronic care plans when looking for information related to consumers’ care needs. Additionally, Behaviour support plans for 10 consumers did not include any information to indicate they were subject to chemical restrictive practices and, therefore, there was no information to guide provision of care, such as non-pharmacological strategies to manage and/or minimise changed behaviours. As such, I find the evidence demonstrates care plans available are not individualised or tailored to guide staff, particularly new or contracted staff, to provide care and services which are in line with each consumer’s current and/or assessed needs and preferences.

I acknowledge the actions taken by the provider to address the deficits identified, however, I have considered that these actions were only initiated either in response to feedback provided by the Assessment Team during the Site Audit or to the Assessment Team’s report and not as a result of the service’s own monitoring processes, including care plan review and reassessment processes. I also acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been achieved, however, I consider that the improvement activities implemented require time to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to all other requirements in this Standard**, care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are undertaken on entry and on an ongoing basis. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop a care plan which generally incorporates each consumer’s needs, preferences, goals and strategies to guide delivery of care and services and manage identified risks. Where risks are identified, referrals to appropriate health specialists are initiated and strategies to minimise risks incorporated into care plans.

Consumers and representatives said they are actively involved in the assessment and planning of consumers’ care and services, and stated they are notified of any changes in care needs that may require reassessment. Care files sampled demonstrated partnership in care is promoted, with care consultations and communication between the service, consumers and representatives related to care evidenced. Consumers and representatives are involved in assessments and planning of care and services on entry and on an ongoing basis and care files demonstrated involvement of General practitioners and Allied health specialists in consumers’ care.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers, staff and others and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers annually and on request. Care plans had been updated following six-monthly review processes and in response to incidents and changes in consumers’ health and condition. Assessments are conducted annually and as required. Care files included input from General practitioners and Allied health specialists, with resulting recommendations incorporated into care plans. Staff are informed of changes to consumers' care needs and services, including through handover processes. Representatives said they are notified promptly when incidents occur and are kept up-to-date with changes in consumers’ care needs. Representatives also stated the communication they receive from the service is exceptional, particularly in relation to any observed alteration in consumers’ health, care or medication changes.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the seven specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(b) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied principles of minimisation of restraint are followed. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* There was no evidence of restraint authorisation or informed consent in the care files for 10 consumers subject to restrictive practice.
* Care files and General practitioner notes did not evidence specific review of as required psychotropic use, trial of dose reduction or alternate strategies or identify if consumer behaviours were ongoing. There was no evidence the service had considered whether the medication continued to be necessary for any of the 10 consumers.
* Consumer C has been prescribed regular and as required psychotropic medication since January 2021, and another psychotropic medication since March 2022. The psychotropic register showed this medication was being administered for anxiety. The representative stated they were aware the consumer had been put on a psychotropic medication a few years ago and confirmed they had spoken to the General practitioner. They understood the medication was prescribed for ‘fluctuating moods and refusal of care’.
* The representative stated the General practitioner informed them in October 2022 that the medication was increased due to the consumer calling out at night. The representative did not recall signing a restraint authorisation form stating although they were aware of one of the psychotropic medications, they were not aware of any other psychotropics or medications prescribed, nor did they understand the benefits or the risks.
* The representative stated they had raised a concern to clinical staff in December 2022 when they noticed the consumer was very sleepy. The General practitioner was asked to review, however, the representative was not aware of any medication changes as a result. For December 2022, the medication profile shows the dose of the regular of the medications was reduced, however, the care file had no evidence of the reported concern of increased sleepiness raised by the representative or notes from the General practitioner related to the medication change.
* The care file shows the as required psychotropic medication was administered on four occasions between May 2022 and January 2023, however, there was no indication alternative strategies were trialled, use of the as required medication order prior to the regular dose being increased, that the medication was used as a last resort or monitored and evaluated for effectiveness.
* Management stated all consumer medications are reviewed every four months by the General practitioner which involves a printout from pharmacy that is signed by the General practitioner. However there is no process, evidence of review or exchange of information between the service and General practitioner in relation to consumers, the chemical restrictive practice or evaluation of current behaviours of concern, strategies or continued need or requirement of psychotropic medications.
* During the Site Audit, management provided the Assessment Team with a copy of the service’s Antipsychotic medication procedure that had been created in response to the Assessment Team’s feedback.
* Six consumer files demonstrated as required medication, including analgesia and psychotropic medications, did not have other strategies trialled prior to administration nor were they evaluated for effectiveness.

The provider’s response consisted of a PCI directly addressing the issues identified in the Assessment Team’s report, as well as supporting documentation. Information included in the response and/or actions initiated and/or planned include, but are not limited to:

* Reviewed and updated the Restrictive practice policy and shared this with all staff.
* Implemented a new Restrictive practice form which maps to the Behaviour support plan and includes interventions to be used prior to restrictive practice.
* Implemented a Restrictive practice authorisation form which includes a section for signed consent and review date. Information relating to the medication will be given to the consenting person.
* The General practitioner has reviewed current medication and reduced the number prescribed based on usage of as required medication in the last three months. This is planned to continue on a three month cycle.
* Education provided to staff on as required medication administration.
* Developed a spot check audit for as required medications and effectiveness.

I acknowledge the provider’s response. In coming to my finding, I have considered that this requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. Based on the Assessment Team’s report, I find this did not occur for Consumer C, specifically in relation to management of chemical restrictive practice.

In coming to my finding, I have considered that while Consumer C was prescribed regular and as required psychotropic medications, the service could not demonstrate the consumer and/or representative had been supported to understand the risks and make an informed decision in relation to use of the medication. The consumer’s representative was not aware of all medications the consumer receiving, the intended use of the medication or the related risks. While the representative had raised a concern relating to the consumer being sleepy, actions taken in response had not been discussed with them. Additionally, where as required medication had been administered, there was no evidence to demonstrate alternative strategies had been trialled prior to administration and effectiveness of the medication was not noted. As such, I find the service did not effectively manage high impact or high prevalence risks associated with Consumer C’s care.

In relation to authorisation, consent and General practitioner review of medications, I have considered this evidence is more aligned to monitoring and management of overall restrictive practice processes and the organisation’s clinical governance framework. As such, I have considered the evidence in my finding for requirement (3)(e) in Standard 8 Organisational governance.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been achieved, however, I consider that the improvement activities implemented require time to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**In relation all other requirements in this Standard,** consumers and representatives were satisfied consumers receive the care and services they need, with involvement of General practitioners and other Allied health services, when needed. Care files sampled demonstrated appropriate management of specific aspects of clinical care, including skin, wounds and diabetes. Staff described specific care needs of individual consumers and how care is delivered based on their needs and preferences.

Advance health directives and end of life care planning are discussed with consumers and/or representatives on entry, during six-monthly care evaluations and where an identified need is observed. Where required, assessments are implemented to determine the trajectory of the illness and phase or level of care required and consultation with General practitioners occurs. For two consumers at the end phase of life, the delivery of care was observed to respect the consumers’ preferences and each had an agreed goal of maintaining dignity and promoting comfort care and support. One representative stated staff have been providing exceptional care to the consumer, are compassionate and caring, allow them to spend quality time together and are ensuring the consumer is not in any pain.

Where changes to consumers’ health are identified, care files demonstrated this is promptly recognised and responded to, including referrals to General practitioners and Allied health specialists, where required. Where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff and care plans updated to reflect any changes to consumers’ care and service needs. Staff demonstrated an understanding of their roles and responsibilities, including identifying and reporting signs of deterioration, and representatives were satisfied the service responds in a timely manner to consumers’ health concerns and felt staff understood was important to consumers, know their preferences for care and did not need to remind or repeat information.

The service demonstrated appropriate application of standard and transmission based precautions used to minimise the risk and prevent transmission of infections to consumers, including in relation to outbreak management. The service has two Infection prevention and control leads who are responsible for promoting and monitoring infection control practices. Monthly infection control surveillance is undertaken and identified trends, issues and actions are discussed and evaluation of practices conducted and reported. Care files demonstrated antibiotics are commenced where clinically indicated and following appropriate pathology testing. Staff demonstrated an understanding of strategies to minimise use of antibiotics, described ways to minimise spread of infection, and stated they have participated in infection control prevention training. Feedback relating to previous outbreaks in the service was positive with consumers and representatives stating staff maintained a calm, caring and professional environment.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | |  |
| Requirement 4(3)(a) | 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. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | 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. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team recommended all seven requirements in Standard 4 Services and supports for daily living met and provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Consumers were satisfied that their needs, goals and preferences for lifestyle were met and their independence, health and well-being was a priority. A lifestyle program, developed in consultation with consumers, is in place and is regularly reviewed to ensure it continues meet their needs, goals and preferences. Consumers are assessed by the Therapy team and provided with the appropriate equipment to enable independence.

Consumers felt their emotional, spiritual and psychological well-being was a priority and three consumers said they have a very good relationship with staff and can always speak to them if they feel down. A number of religious group and one-to-one programs, focused on consumers’ emotional and psychological well-being, are facilitated by the service, and where consumers are identified as experiencing low mood, they are encourage to participate in meaningful activities or tasks. Care files also demonstrated referral to appropriate Allied health services to support consumers’ emotional and psychological well-being are initiated, where required.

Consumers felt supported and encouraged to engage with their community, to maintain relationships of choice and do things of interest to them. An activities calendar is maintained and includes a variety of group and individual activities. Observations confirmed consumers have social and personal connections and participate in activities within and outside the organisation’s service environment.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely are referrals are initiated. Regular multidisciplinary meetings are held where staff can refer consumers for review where changes or deterioration in a consumer’s health or well-being are identified. Staff described how they are kept up-to-date with consumers’ changing needs and preferences and consumers stated they did not have to repeat information to staff members about their needs and preferences for care and services.

Four consumers said meals provided are of suitable quality and quantity, are beautifully presented and options are available. They did state, however, at times the meals are somewhat boring. The service predominantly offers vegetarian meals in line with the religious beliefs of Seventh Day Adventists. Management are aware that consumers do not always enjoy the meals and are currently implementing a number of improvements to the meal service at an organisational level. Observation of meal services confirmed meals are varied and of suitable quality and quantity and consumers can request a different meal if they do not like what is on the menu. All consumers appeared to enjoy their meals, the service felt unrushed and consumers were observed using specialised crockery and utensils to maintain a level of independence.

Equipment, required to support delivery of services, was observed to be safe, suitable clean and well-maintained. Consumers sampled felt safe when using equipment and said it was suitable for their needs.

Based on the Assessment Team’s report, I find all requirements in Standard 4 Services and supports for daily living compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team recommended all three requirements in Standard 5 Organisation’s service environment met and provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Consumers sampled confirmed the service environment is welcoming and encourages a sense of community and belonging. The service is located over two levels and staff described how they assist consumers to use a lift to connect them to the lower common areas. Consumers are encouraged to personalise their rooms and make the service their home and consumers were observed interacting with each other and utilising communal and garden areas.

The service environment was safe, clean, and well maintained with consumers able to move freely both indoors and outdoors. Cleaning is undertaken in line with a schedule and staff described cleaning processes for consumer rooms and high touch points. Maintenance, processes are in place and staff described how they report maintenance issues and hazards, in line with the service’s processes. All furniture, fittings and equipment was observed to be safe, clean, and well maintained and representatives were satisfied the service provides and maintains equipment that is required for consumers’ care needs.

Based on the Assessment Team’s report, I find all requirements in Standard 5 Organisation’s service environment compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Assessment Team recommended all four requirements in Standard 6 Feedback and complaints met and provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Consumers sampled indicated they are encouraged and supported to provide feedback and make complaints and felt comfortable speaking directly to management. A feedback and complaints box and forms were observed to be easily accessible to consumers and one consumer stated they can ask staff to assist them to complete a feedback form, as required. Consumer meeting forum minutes demonstrated consumers are encouraged to provide feedback through this forum and the service conducts regular surveys to gain insight into consumer satisfaction.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and information relating to these processes and services was observed displayed around the service, readily accessible to consumers, staff and visitors. Most consumers and staff sampled could not clearly describe other services available to raise and resolve complaints, however, stated the service resolves their complaints efficiently and they do not feel the need to access external services. In response to this, management provided printed information and discussed advocates, language services and other methods for raising and resolving complaints at a consumer meeting forum held during the Site Audit.

Policy and procedure documents are available to guide staff practice with regard to acknowledging and actioning feedback and complaints. Documentation sampled demonstrated complaints are recorded and appropriate and timely action is taken in response to feedback and complaints. Consumers said when they make a complaint about care and services or suggestions for improvement, staff respond and resolve issues in a timely manner and staff and management apologise when things go wrong and check in to ensure issues they have raised have been resolved to their satisfaction.

The service demonstrated how feedback and complaints are reviewed and used to identify and drive continuous improvement. Complaints and feedback are recorded and analysed on a monthly basis, with results discussed at staff and consumer/representative meeting forums. Consumers were satisfied their feedback is used to improve care and services.

Based on the Assessment Team’s report, I find all requirements in Standard 6 Feedback and complaints compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Assessment Team recommended all five requirements in Standard 7 Human resources met and provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

The service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Adequate staffing levels across the service were demonstrated with strategies in place for planned and unplanned leave to maintain quality care and services. Staff were satisfied there were sufficient staff available to meet consumers’ needs and indicated they have enough time to undertake their duties. Most consumers were satisfied there were enough staff and stated they do not have to wait a long time for their call bell to be answered.

Consumers and representatives said staff treat consumers with respect, are responsive to their needs and provide care in a kind and caring manner. Staff were observed interacting with consumers in a kind, caring and respectful manner and consumers requiring assistance with mealtime and recreational activities were being assisted in a dignified way.

There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles. Position descriptions outline minimum qualification requirements and duty statements are available to guide staff in their roles. There are processes to monitor professional registrations to ensure they are current and up-to-date. Staff said they complete mandatory training relevant to their role and demonstrated knowledge specific to the care and service provision of older people. Consumers and representatives were confident staff have the qualifications and knowledge to effectively perform their roles.

The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these Standards. New employees complete onboarding training and undertake buddy shifts prior to working independently. Ongoing, staff are required to complete training relevant to their role, including mandatory training components. There are processes to ensure mandatory training is completed. Staff described completing an induction, buddy shifts as well as various online training modules and felt supported by management. Additional training needs are identified through review of clinical care indicators and documentation confirmed a variety of toolbox training to staff, including in relation to pain, dehydration, dignity and care planning had been provided.

The service has a staff performance framework which ensures staff performance is regularly assessed, monitored and reviewed. Probationary performance appraisals occur after three months with the process used to ensure new staff are a good fit for the organisation. Ongoing, performance appraisals are undertaken annually unless performance issues identified. Staff sampled felt supported through the performance review process.

Based on the Assessment Team’s report, I find all requirements in Standard 7 Human resources compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(e) in Standard 8 Organisational governance not met.

**Requirement (3)(e)**

The organisation demonstrated effective practices and processes relating to antimicrobial stewardship and open disclosure. However, the Assessment Team were not satisfied the organisation demonstrated aspects of a clinical governance framework for minimising the use of restraint. The Assessment Team’s report provided the following evidence relevant to my finding:

* For the five sampled consumers, informed consent from consumers and/or their representatives for administration of psychotropic medication was not evidenced. The service relies on General practitioners to discuss reasons for prescription and risks of restrictive practice with consumers and/or their representatives.
* The service’s psychotropic medication register and medication profile showed Consumer D is prescribed a psychotropic medication twice a day without a supporting diagnosis, relevant Behaviour support plan or alternatives to trial prior to administering medication.
* The organisation’s Restraint use policy does not include a section on Behaviour support plans or offer guidance relating to information required to be included in the plan.
* Non-pharmacological interventions are not consistently trialled prior to use of psychotropic medication. Progress notes for five sampled consumers only state medication was administered and did not identify monitoring or evaluation of effectiveness.
* The service does not ensure psychotropic medication is used for the least amount of time. Care files for the five sampled consumers showed while they are each prescribed as required psychotropic medication this has not been administered for more than 12 months. There has been no consideration to cease the as required dose and it remains on each of the five consumers’ medication profiles and available for registered staff to make the decision to administer as a behaviour management strategy.
* An open disclosure policy is not in place, however, consumers and staff sampled confirmed staff use open disclosure principles in their daily practice.

In coming to my finding, I have also considered evidence presented in requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers and requirement (3)(b) in Standard 3 Personal care and clinical care, specifically:

* Ten Behaviour support plans did not indicate the consumers were subject to chemical restrictive practice or include monitoring or individualised strategies to trial prior to administration of psychotropic medication.
* Management stated all consumer medications are reviewed every four months which involves a printout from pharmacy that is signed by the General practitioner. However there is no process, evidence of review or exchange of information between the service and General practitioner in relation to consumers, the chemical restrictive practice or evaluation of current behaviours of concern, strategies or continued need or requirement of psychotropic medications.

The provider’s response consisted of a PCI directly addressing the issues identified in the Assessment Team’s report, as well as supporting documentation. Information included in the response and/or actions initiated and/or planned include, but are not limited to:

* Implemented a new Restrictive practice authorisation form which includes a section for signed consent, review date and clearly indicates diagnoses and behaviours.
* The General practitioner has reviewed current medication and reduced the number prescribed based on usage of as required medication in the last three months. This is planned to continue on a three month cycle.
* Reviewed and updated the Restrictive practice policy and shared this with all staff.
* Implemented a Restrictive practice form which maps to the Behaviour support plan and includes risks and interventions to be used prior to restrictive practice being used.
* Created an Open disclosure policy and educational posters.

I acknowledge the provider’s response. I have considered effective systems and processes have been demonstrated in relation to antimicrobial stewardship and open disclosure. However, I find the organisation’s clinical governance framework and systems were not effective to ensure sufficient oversight of how restrictive practice is used and to identify opportunities to minimise restrictive practice use.

I have considered the organisation’s policies and procedures and legislative requirements have not been consistently applied in relation to use of restraint. Consumers sampled subject to restrictive practices, specifically chemical, did not have the appropriate consents, authorisations, management and monitoring strategies in place, nor were alternative, non-pharmacological strategies demonstrated to have been consistently trialled prior to administration. While Behaviour support plans were in place, for 10 consumers, the plans did not indicate the consumers were subject to chemical restrictive practice and, therefore, did not include monitoring or individualised strategies to trial prior to administration of psychotropic medication. Additionally, while there is a process for review of consumers’ medications by a General practitioner on a four monthly basis, there was no indication that this process had been effective in monitoring use of psychotropic medications or identifying opportunities where use of medications could be minimised or ceased. As such, I find the organisation’s systems and practices do not ensure restrictive practices are managed in accordance with legislative requirements, use of restrictive practices is monitored or opportunities to minimise use of restrictive practices identified and actioned.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been achieved, however, I consider that the improvement activities implemented require time to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-compliant.

**In relation to all other requirements in this Standard**, consumers are engaged in the development, delivery and evaluation of care and services through feedback processes, care plan evaluation process, surveys, meeting forums and focus groups. Consumers also provide input into the staff appraisal process for new employees. Consumers and representatives said management and other staff consult with them directly regarding consumers’ likes, dislikes and preferences for care and check in at regular intervals to review the care they receive.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Board receives regular reports which include collated information relating to clinical care, incident reports, including the Serious Incident Response Scheme, complaints and other risks within the service. The Board uses this information to drive improvements in care and safety of consumers.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and the Board is aware and accountable for the delivery of services.

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including use of an incident management system.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 8 Organisational governance compliant.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)