

**Performance Report**

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| Name: | Amaroo Village Buckley Caring Centre |
| Commission ID: | 7093 |
| Address: | 60 Stalker Road, GOSNELLS, Western Australia, 6110 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 15 October 2024 to 16 October 2024 |
| Performance report date: | 21 November 2024 |
| Service included in this assessment: | Provider: 923 Amaroo Care Services Inc Service: 4621 Amaroo Village Buckley Caring Centre |

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 Amaroo Village Buckley Caring Centre (**the service**) has been prepared by A Kasyan, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumes/representatives and others;
* the provider’s response to the assessment team’s report received on 7 November 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not compliant  |
| **Standard 3** Personal care and clinical care | **Not compliant** |
| **Standard 8** Organisational governance | **Not 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)(e):**

* Ensure staff conduct regular review of consumers’ care plans, following incidents or changes in consumers’ needs.

**Standard 3 Requirement (3)(b):**

* Ensure all risk associated with the care of consumers are timely identified, mitigated and managed.

**Standard 8 Requirement (3)(d):**

* Ensure effective risk management framework and consistent incident documentation, reporting, and staff compliance with policies.

# Standard 2

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| Ongoing assessment and planning with consumers |  |
| 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. | Not Compliant |

Findings

This Quality Standard is assessed as non-compliant as requirement 2(3)(e) has been assessed as non-compliant.

The Assessment Team’s report shows, although policies require a post-falls risk assessment after each incident, the service did not consistently perform these assessments for a consumer who had experienced multiple falls. In some cases, documentation confirmed the completion of the post-fall procedures, but the falls risk assessment was missing for others.

For another consumer with recent incidents of physical and verbal aggression, the behaviour support plan was not effectively reviewed or updated for effectiveness following these incidents. Documentation did not evidence staff evaluated whether current strategies were effective or adjusted them as needed.

In its response, the provider acknowledged the Assessment Team’s findings and provided evidence of corrective actions taken since the assessment contact. They reported implementing a new falls management and monitoring process, attaching documentation on this improvement, and initiating a comprehensive review of all behaviour support plans to ensure they are tailored to individual needs.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with requirement 2(3)(e) due to staff not undertaking regular, effective reviews of care and behaviour support plans after incidents. While the service has policies and procedures in place to guide the regular review of care plans, the evidence shows inconsistencies in applying these reviews effectively following incidents or changes in consumers’ needs.

I acknowledge the provider’s response and supporting documentation demonstrating actions that have been taken since the assessment contact. Although the provider has demonstrated commitment to addressing these deficiencies in staff practice, the evidence shows corrective actions have yet to demonstrate consistent or effective application.

# Standard 3

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| Personal care and clinical care |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

This Quality Standard is assessed as non-compliant as requirement 3(3)(b) has been assessed as non-compliant.

The Assessment Team’s report shows the service does not effectively manage high impact or high prevalence risks associated with the care of consumers, specifically in relation to management of falls and behaviours.

The report found falls management approach is not individualised and not proactive. The care plans for consumers at high risk of falls were generic, relying on a "tick box" system without tailored strategies to address each consumer’s unique risks. One consumer identified as a high falls risk experienced repeated falls (7 since late July 2024); however, the management strategy did not change in response to these incidents. While a physiotherapist recommended more appropriate footwear, observations during the assessment contact showed the consumer continued to wear footwear which did not align with recommendations. Visual checks for close monitoring of consumers were sometimes documented ahead of schedule.

In relation to behaviour management, the report shows ineffective management of 2 consumers’ changed behaviours (physical and verbal aggression) impacting the safety of both consumers and staff. Consumers showing aggressive and disruptive behaviours toward others have not received individualised support or effective intervention.

Staff reported feeling unsafe approaching consumers during escalations, and incidents where consumers showed aggression were inconsistently documented. Behavioural monitoring charts showed recurring issues, but staff did not complete incident reports nor reassess behaviour management strategies.

The Assessment Team noted the multidisciplinary meetings, which are meant to discuss risks, did not support in-depth analysis or repeated incidents or check whether strategies put in place were working. Documentation did not evidence a comprehensive follow-up on whether interventions were successful, and behaviour-related incidents were often left out of discussions.

In its response, the provider acknowledged the Assessment Team’s findings and provided evidence of corrective actions taken since the assessment contact:

* For falls management, the provider issued a memorandum to ensure accurate visual charting and awareness among staff.
* In relation to behaviour support, the provider introduced additional behaviour management training and daily reviews by clinical nurse managers to ensure documentation and intervention compliance.
* To improve multidisciplinary meetings, the provider has updated the multidisciplinary meeting template to include sections for assessing the effectiveness of strategies, with a focus on timely risk identification.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with requirement 3(3)(b) due to ineffective management of high-impact risks related to falls and behaviours. I acknowledge the provider’s response and supporting documentation demonstrating actions that have been taken since the assessment contact.

Although the provider has demonstrated commitment to addressing the deficits, the evidence shows corrective actions have yet to demonstrate consistent or effective application.

# Standard 8

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| Organisational governance |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:1. managing high impact or high prevalence risks associated with the care of consumers;
2. identifying and responding to abuse and neglect of consumers;
3. supporting consumers to live the best life they can
4. managing and preventing incidents, including the use of an incident management system.
 | Not Compliant |

**Findings**

This Quality Standard is assessed as non-compliant as requirement 8(3)(d) has been assessed as non-compliant.

The Assessment Team’s report shows significant deficits in the service’s ability to manage high-impact risks, identify and respond to incidents, and follow mandatory reporting requirements. Documentation for several consumers with behaviours, including aggression that placed safety and wellbeing of other consumers and staff at risk, showed repeated instances where incidents were not logged, reported, or investigated in line with the provider’s policies.

On multiple occasions, between August and October 2024, staff documented aggressive behaviours in progress notes but did not escalate them as formal incidents which is not in line with the organisational policies on incident documentation.

The Assessment Team found serious incidents, including behavioural incidents and financial abuse of a consumer, were not reported to Serious Incidents Response Scheme (SIRS) as required. Management were unaware of these incidents and acknowledged failures in the current process, including staff not following reporting procedures for serious incidents.

The Assessment Team’s report identified delays in reviewing high-risk consumer care plans, such as a dignity of risk form for a high-falls-risk consumer, last updated in July 2024 rather than monthly as required by the service’s risk matrix. The provider advised it was due to an outdated information system but has not shown evidence during the assessment contact that this has been effectively implemented until their planned system upgrade in January 2025.

In its response, the provider acknowledged the Assessment Team’s findings and provided evidence of corrective actions taken since the assessment contact. The provider updated the SIRS register and provided staff training focused on abuse, neglect, and restrictive practices.

The provider stated and provided evidence of additional training on implementation of incident documentation and SIRS requirements. Attachments included details of training sessions and updated incident records.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with requirement 8(3)(d) because the service’s governance structure and incident management processes are not adequately protecting consumers, particularly in relation to managing high-risk behaviours, enforcing incident reporting protocols, and ensuring effective oversight and response to incidents.

I acknowledge the provider’s corrective actions and updated plan for continuous improvement. However, I find these actions are reactive rather than part of a proactive governance system to prevent recurrence. The management’s lack of awareness of these incidents shows the service’s oversight and monitoring mechanisms are not robust. The provider did not demonstrate in its response these actions have resulted in consistent and systematic improvements across all staff.

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)