Anglicare SQ St John's Home For Aged Men

Performance Report

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**Commission ID:** 5050

**Provider name:** The Corporation of the Synod of the Diocese of Brisbane

**Assessment Contact - Site date:** 22 June 2022 to 23 June 2022

**Date of Performance Report:** 29 July 2022

# Performance report prepared by

Susan Turner, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(d) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the 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 responses to the Assessment Contact - Site report received 15 July 2022 and 27 July 2022.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found that the service had policies and procedures in relation to the use of restrictive practices and behaviour support planning and that these documents referenced the Quality of Care Principles 2014. The procedures outline the organisation’s commitment to using restrictive practices as a last resort and provide guidance in relation to assessments, authorisations and monitoring practices that are required.

However, processes applied at the service relating to the use of restrictive practices, particularly the use of chemical restrictive practices had not been effective in ensuring assessments, authorisations and monitoring were established for consumers who received psychotropic medications for the purpose of influencing their behaviour.

The Assessment Team brought forward information that the service identified one consumer was subject to chemical restrictive practice. The named consumer had been commenced on an anti-psychotic medication in April 2022 for the purpose of managing behaviour, without a corresponding diagnosis. This was not identified by the service as being a form of chemical restrictive practice until 21 June 2022, a period of approximately 10 weeks. Risk assessments and authorisations related to the use of this medication had not been completed.

The Assessment Team reviewed the service’s psychotropic medication register and identified a number of named consumers who were receiving regular and/or ‘as required’ psychotropic medications for reasons including anxiety and agitation, without a diagnosis to support the use of the medication. These consumers had not been identified by the service as being possibly subjected to a chemical restrictive practices and did not have the appropriate authorisations or consents in place. Further, many of these consumers did not have a behaviour support plan in place. Documented evidence relating to medication reviews was inconsistent, with some consumers identified as not having had these types of medications reviewed for more than 12 months.

The assessment contact report states that the service’s Quality Improvement Register was updated during the site audit to include a review of restrictive practice protocols by the organisation’s head office and a review of all consumers receiving psychotropic medications to determine the number of consumers subject to chemical restrictive practice and to ensure assessments, consents and authorisations are completed.

The approved provider, in its responses to the assessment contact report (15 July 2022 and 27 July 2022) states that a case review conducted prior to the assessment contact, on 21 June 2022, by senior management staff within the organisation identified oversights in classification and documentation associated with chemical restrictive practices and initiated a number of actions in response to this. A plan for continuous improvement to address deficiencies in this area has been submitted and includes the following actions which the approved provider has said are completed:

* an independent review of medication has been conducted
* discussions have been held with medical officers responsible for the care of consumers, additional resources have been provided and referrals have been made to mental health services for some consumers
* registered nurses have been provided with additional education and training in relation to restrictive practices and chemical restrictive practices
* the psychotropic register has been updated.

The approved provider’s responses including the plan for continuous improvement identifies a number of actions that are ongoing or are in progress including:

* daily handover includes reference to chemical restrictive practice
* processes to improve clinical monitoring and oversight are being established that ensure contact is made with the authorised decision maker, authorisation by the medical officer occurs and the behaviour support plan is established
* the electronic information system has been upgraded to reflect the requirements of the behaviour support plans; those consumers who currently have a restrictive practice in place are having their behaviour support plans upgraded following review by their medical officer
* a senior clinician from the Anglicare Specialist Dementia Care Unit will review all documentation associated with chemical restrictive practice and behaviour support plans
* the service has recruited a care coordinator and this role will enhance the monitoring and supervision of clinical care with a focus on chemical restrictive practice
* further education and training is planned for registered nurses in relation to chemical restrictive practice
* a medication advisory committee meeting with a focus on psychotropic medication use has been scheduled
* medical officers will be able to participate in an information session with specialists from the Specialist Dementia Care Unit
* a medication advisory committee meeting scheduled for August 2022 will provide an opportunity for medical officers and the pharmacist to focus on education
* a review by the organisational Governance, Risk and Assurance team has been scheduled to ensure compliance with the use of psychotropic medication is evidenced in clinical documentation.

The service demonstrated that other aspects of personal and clinical care optimised consumers’ health and well-being and consumers and representatives interviewed by the Assessment Team spoke positively about the care that consumers receive. The Assessment Team reviewed the care of consumers with long term health conditions and specialised nursing care needs including complex wounds and chronic pain.

For consumers with complex wounds, individualised risks had been identified, assessments had been completed, a wound management plan was in place and regular review by medical officers and wound care specialists had occurred where appropriate.

Consumers with chronic pain had been seen by allied health such as physiotherapists. Pain management included non-pharmacological interventions such as massage and heat packs as well as analgesia. Where a need was identified, referrals had been made to a pain specialist.

The assessment contact report includes information that demonstrates some aspects of personal and clinical care are individualised and optimise consumer’s health and well-being. While the approved provider has taken action to strengthen care delivery in relation to chemical restrictive practice and improve consumer outcomes these actions are yet to be fully implemented and evaluated for effectiveness. I am satisfied that consumers did not receive clinical care that was best practice and that optimised their well-being particularly in relation to the use of chemical restrictive practices.

I find this requirement is non-compliant.

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

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

The service has a documented risk management framework that guides staff in the identification, documentation and management of risk.

Policies are available to staff on high impact and high prevalence risks associated with the care of consumers. A system is in place to document and record high impact and high prevalence risks associated with consumers’ personal and clinical care. Clinical indicator data is analysed monthly and is reviewed at the service’s Quality Meeting where it informs improvement activities for individual consumers and the service more broadly.

Staff said that risk assessments are completed on entry to the service and strategies are implemented that are in line with consumers’ preferences. Staff confirmed that high impact and high prevalence risks are reviewed on a monthly basis and are analysed, and where trends are identified action is taken.

Most consumers and representatives said they feel that the consumer’s personal and clinical needs are met and provided examples of how pain is managed and specialised nursing care needs are met.

Care planning documentation demonstrated that risks and contributing factors are identified and that risk minimisation strategies are specified.

The Assessment Team reviewed clinical documentation for a number of consumers including those who are prone to falls and who have poor mobility, consumers who smoke cigarettes, consumers with compromised skin integrity and consumers who exhibit complex behaviours including aggression. The Assessment Team found risk assessments had been completed, clinical equipment such as hip protectors and mobility aids was available, referrals had been made to allied health and specialist service providers and detailed risk mitigation strategies were documented.

I am satisfied that there is effective management of high impact and high prevalence risks associated with the care of consumers.

I find this requirement is compliant.

# STANDARD 7 Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 7 Requirements

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

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

Consumers and representatives said they were satisfied that staff were trained and equipped to perform their role. Consumers said that staff knew what they were doing and that they had no complaints about care provided.

Staff could describe the training, support and professional development they receive during orientation and on an ongoing basis. A probationary period supports new staff and a review of performance and knowledge is an element of the process. Staff described the processes that alerts them as to when mandatory training is due to be completed and said that management monitor completion. They said they can approach management staff if they desire additional training opportunities. Staff were able to demonstrate that they have participated in mandatory training and competency assessments including restrictive practices, the Aged Care Quality Standards and the Serious Incident Response Scheme.

Management said that the education and training program incorporates an orientation program, mandatory and role specific training and this is provided through a combination of on-line training and face to face training. Training needs are identified through monthly meetings, feedback forums, monitoring and observations by clinical staff and team leaders.

The Assessment Team observed posters outlining the requirements of restrictive practices on noticeboards and observed staff completing education on-line.

While management and registered staff demonstrated general knowledge of the different types of restrictive practices and requirements in relation to application and monitoring, knowledge deficits were identified in relation to chemical restrictive practices.

The approved provider’s response to the assessment contact report states the education and training is integral to staff knowledge of chemical restrictive practice. The service’s plan for continuous improvement states the following actions to address staff knowledge were completed by 31 March 2022:

* online learning modules that include restrictive practice were completed by staff, and online refresher modules continue to be delivered
* resource books that include relevant fact sheets have been placed in the nurses’ station
* restrictive practices have been raised at staff meetings and addressed at toolbox sessions
* posters addressing restrictive practice have been placed in staff areas to raise awareness.

Additionally, the service has completed/is implementing the following:

* registered nurses received training from a pharmacist 8 July 2022 and an additional session is scheduled for 8 August 2022
* medical officers were provided with information about restrictive practice on 8 July 2022
* a care coordinator role has commenced and the role will include a focus on education tailored to leadership and best practice scenarios related to chemical restrictive practice
* compliance reports relating to completion of mandatory training are run fortnightly and reviewed by management staff and evidence of staff completion including in relation to restrictive practice were provided
* regular review of the mandatory quality indicator data occurs at the monthly quality meeting, attended by all levels of staff; this affords an opportunity to provide ongoing staff education.

I am satisfied that the workforce is trained and supported to deliver the outcomes required by these standards and that there are mechanisms in place to ensure staff have the appropriate knowledge and skills in relation to chemical restrictive practice.

I find this requirement is compliant.

# STANDARD 8 Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Not all requirements were assessed and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 8 Requirements

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The service demonstrated effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Staff said they have access to the information such as policies and procedures and that information is communicated to them through staff meetings, electronic messaging, and training and education programs. Consumers and representatives expressed high levels of satisfaction with the care consumers receive and one representative commented positively about the information they are provided by the organisation.

Management advised that opportunities for continuous improvement are identified through a range of sources including audits, consumer and representative feedback, survey results, consumer meetings, incident data, hazards and through the introduction of new legislation. Continuous quality improvement initiatives are tracked and managed through the Quality Improvement Register and examples of improvements were brought forward.

Management described the way they seek changes to budget or expenditure to support consumers’ changing needs. They said an annual budget is established by the executive Leadership Team in consultation with the Group Manager and the Service Manager. Management said the Board is responsive in providing additional funding for the service and consumers when a need is identified. An example was provided where a proposal for additional staff, over and above budget, was submitted to head office and was subsequently approved.

The service demonstrated that there are systems in place to monitor the workforce and ensure that safe, effective, quality care is delivered. Policies and procedures outline roles, responsibilities and accountability.

Consumers and representatives are encouraged to provide feedback and make complaints and appropriate action is taken and improvements are made in response to this feedback.

The service was able to demonstrate how the organisation tracks changes to aged care law and communicates these to staff, and how the organisation knows that its incident management system and Serious Incident Response Scheme (SIRS) processes are working.

The service receives notifications from bodies such as the Aged Care Quality and Safety Commission, Queensland Health, the Department of Health and the Public Health Unit. The organisation generally has governance mechanisms in place to track, audit and monitor compliance with legislative and regulatory requirements. Changes in legislation are communicated to the service’s management staff and this in turn is then communicated to staff via meetings, emails, toolbox talks and staff training.

The service has implemented mandatory SIRS training for all staff which includes online modules and toolbox sessions. Staff interviewed confirmed their attendance at training and demonstrated an understanding of reporting requirements. The Assessment Team reviewed the service’s incident reporting register and identified that incidents had been reported appropriately and within required timeframes.

The service has taken action to address deficiencies that were previously identified under this requirement. Actions include:

* the service has established mechanisms for monitoring call bell data, and analysing performance
* policies and procedures relating to behaviour support planning and the use of restrictive practice are available to staff through the organisation’s document library
* policies and procedures relating to behaviour support planning and the use of restrictive practice have been distributed to staff and discussed with them; this information is also included in the service’s orientation.

While the Assessment Team brought forward deficiencies in the way the service monitors its compliance with its legislative responsibilities relating to chemical restraint, this information was considered under other Standard 3 and there are policies and procedures that support the workforce to understand the organisation’s obligations. Further to this, the approved provider’s responses to the assessment contact report outline a number of actions that have been taken that will strengthen the service’s performance in this area including the appointment of a care coordinator role whose role will include a focus on restrictive practices, the implementation of weekly clinical risk meetings and monthly quality meetings.

I am satisfied that governance systems are in place and are generally effective. I find this requirement is compliant.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The service demonstrated that overall, it has systems in place for the delivery of safe, quality clinical care and that it has a commitment to continuously improving services.

Management staff described the clinical governance framework and could demonstrate that it included engagement with a wide variety of health care staff to improve the quality of clinical care including registered nursing staff, medical officers, specialist health care providers and allied health professionals such as pharmacists. Clinical reviews occur, risk management processes are established, education and training in clinical matters is provided to staff and monitoring mechanisms are in place.

The service provided a documented clinical governance framework and policies and procedures relating to antimicrobial stewardship, minimising the use of restraint and open disclosure.

Staff said they had received education about these policies and were generally able to describe what the policies meant for them in a practical way and could provide examples of their relevance to their work.

Staff could describe the way they minimise the risk of infection through hand hygiene practices and use of personal protective equipment. Management staff said that the care manager is responsible for the management and oversight of anti-microbial stewardship and that the service obtains pathology results for consumers prior to the administration of antibiotics.

Management staff provided examples of how they had utilised the principles of open disclosure in managing complaints and improving processes and procedures within the service. The Assessment Team reviewed the service’s incident reporting system and the compliments and complaints register and found records demonstrated that staff use the principles of open disclosure in their communications with consumers and representatives.

The service has an established procedure for the minimisation of the use of restrictive practices, which promotes that restraints are considered a last resort, only to be used when all other alternatives have been tried.

The service has taken action to address deficiencies that were previously identified under this requirement. Actions include:

* The introduction of a Behaviour Support Planning and Use of Restrictive Practice procedure. Review of staff meeting minutes and other related documentation by the Assessment Team identified that the procedure had been disseminated and discussed with staff.
* Training in relation to restrictive practices was included in the service’s orientation and was completed by all staff in March 2022.

The assessment contact report includes information that chemical restrictive practice was not consistently managed in accordance with required guidelines. I have considered this information under Standard 3 and I have also considered its relevance under this requirement. The approved provider’s responses to the assessment contact report advise that action has been taken to strengthen the clinical governance framework. Actions include:

* The service has commenced a review of restrictive practices documentation and behaviour support plans for consumers who are identified in the service’s psychotropic register.
* The care coordinator is liaising with the Specialist Dementia Care Unit Coordinator to facilitate processes to support clinical governance. Areas for discussion include weekly clinical risk meetings, psychotropic medication reviews, monitoring schedules and documentation improvement opportunities.
* A collaborative service medication advisory committee meeting is scheduled for August 2022. Medical officers and the pharmacist will focus on psychotropic medication usage and best practice.
* A quality assurance review is scheduled for August 2022 to ensure that psychotropic medication use is evidenced appropriately within documentation.
* External assessment findings will be tabled for discussion at the next Quality and Safeguarding Committee Meeting to determine the effectiveness of ongoing monitoring and quality assurance activities.
* Ongoing monitoring of quality and safety data at all levels of the organisation, including mandatory quality indicators will assess benchmarks in relation to restrictive practices at all Anglicare Residential Aged Care Facilities.

While the assessment contact record includes information that the management of chemical restrictive practice was not appropriate at the time of the assessment contact I have considered the weight of this information under Standard 3. I am satisfied that clinical leadership is evident within the organisation, that there are established systems for improving the safety and quality of clinical care and that there are mechanisms to review the effectiveness of the clinical governance framework including in relation to antimicrobial stewardship, open disclosure and minimising the use of restraint.

I find this requirement is compliant.

# 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.

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1. is best practice;
2. is tailored to their needs; and
3. optimises their health and well-being.