

**Performance Report**

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| Name: | Baptistcare William Carey Court |
| Commission ID: | 7267 |
| Address: | 450 Bussell Highway, BUSSELTON, Western Australia, 6280 |
| Activity type: | Site Audit |
| Activity date: | 29 October 2024 to 1 November 2024 |
| Performance report date: | 12 December 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 5431 Baptistcare William Carey Court |

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 Baptistcare William Carey Court (**the service**) has been prepared by Jemma Wilson, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Assessment Team’s report received 4 December 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **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 | **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 7 requirement (3)(e)**

* Ensure regularly assessment, monitoring and review of the performance of each staff member, including agency staff, is undertaken to evaluate how they are performing their role, enable poor practice to be identified and identify, plan for and support any training, and development they need.

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

* Ensure the clinical governance framework is effectively implemented and is addressing minimisation of restrictive practices, specifically in relation to consumers subject to chemical restraint usage. Ensure the framework is reviewed for effectiveness.
* Ensure behaviour support plans are reviewed and individualised to the consumer and include sufficient information to support effective behaviour management strategies to reduce or minimise the need for restrictive practice usage.
* Ensure authorised consents for consumers subject to restrictive practice are regularly reviewed and monitored in line with legislative requirements.

# Standard 1

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| 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

Consumers and representatives confirmed consumers are treated with dignity and respect, and care and services delivered are culturally safe. Consumers confirmed staff interactions are kind and considerate, respect their privacy and confidentiality and described how the service communicates care and services, and how.

Staff described how they deliver care and services in a respectful manner and communicate with consumers effectively in line with their needs and preferences. Staff demonstrated they understood the identity, culture, and diversity of each consumer to ensure care and services is provided in a dignified way. Staff maintained consumers privacy by knocking on consumers’ doors and obtaining consent before entering and ensuring visiting health professionals visit in their rooms.

Staff and management described how they support consumers to undertake activities of risk through consultation of the risks and mitigation strategies implemented. Management described how consumers are provided with a handbook outlining personal care and services, with additional information available to consumers and representatives in the reception area.

Care documentation included personalised preferences and information regarding consumers’ identity, culture, and diversity. Care documentation reflected where consumers are supported to take risks to live the life they wish and to achieve consumer-centred solutions. Electronic care documentation is controlled by security access, ensuring consumer information is kept confidential. Staff access these in their offices or via an electronic touch screen tablet.

Based on the assessment teams report, I find all requirements in Standard 1 Consumer dignity and choice compliant, therefore the Standard is compliant.

# Standard 2

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| 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. | 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

Consumers and representatives described how the service identifies risks and uses this information to plan the care they receive. Consumers confirmed the service undertakes a comprehensive assessment process in consultation with them on admission and includes assessing their current needs, goals and preferences, end of life wishes, and risks associated with their health and well-being. Consumers and representatives confirmed the service discusses care plans and services on an ongoing basis and they have access to care plans if requested.

Care documentation included personalised needs, goals, and preferences of consumers and captured advance care directives and personal wishes for end of life care. Care documentation showed other health care providers are involved in assessment and planning of care and services.

Staff demonstrated knowledge of the service’s assessment and planning processes, including the assessment of risks, needs, goals and preferences, and end of life wishes. Additionally, staff described communication processes to ensure information is shared and confirmed consumer care plans are current and have sufficient information documented to inform safe and effective care and services.

Management confirmed care plans are updated regularly or when changes occur to ensure they remain current and appropriate to each consumer’s needs.

Policies and procedures are in place to guide staff practice on when to re-assess consumers, including 6 monthly, after an incident or as clinically indicated. Additionally palliative and end of life procedures are in place to guide staff when having end of life discussions with consumers and representatives.

Based on the assessment team’s report, I find all requirements in Standard 2 Ongoing assessment and planning with consumers compliant, therefore the Standard is compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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 assessment team recommended requirement (3)(d) as not met, and all other assessed requirements met.

**In relation to requirement (3)(d)**

The Assessment Team recommended requirement (3)(d) not met, as they were not satisfied deterioration or changes in consumers condition was managed effectively and responded to in a timely manner. The assessment team’s report included the following evidence relevant to my finding:

Care documentation for 2 consumers, 6 months prior to the site audit, showed neurological observations were not undertaken in line with the organisations post fall policy, nor did care documentation show a detailed assessment of pain undertaken, including the completion of pain charting although progress notes showed indications of pain documented by staff.

Additionally for one consumer, care documentation showed signs of clinical deterioration, such as confusion, loss of appetite, complaining of pain and being unsettled at night. Care documentation showed a urinalysis was conducted however, no further assessments or investigations were documented nor was there evidence of a general practitioner’s referral.

The provider did not agree with the assessment team’s recommendation and provided additional information and evidence relevant to my finding. The providers response included a plan for continuous improvement and additional commentary and information describing how recent improvements have been implemented.

The completed plan for continuous improvement showed the completion of online training for clinical staff which included assessment of changes to a consumer’s condition, clinical assessment and responding to falls. The provider asserted an internal audit of care documentation has been undertaken post site audit to identify if systemic issues are present. Documentation shows the internal audit completed identified no issues with post falls management and monitoring for the sampled consumers.

While I acknowledge the Assessment Team’s report, I have come to a different view and find deterioration or changes in consumers condition is managed effectively and responded to in a timely manner. In coming to my finding, I acknowledge the evidence describing deficiencies for 2 named consumers in recognising and responding to changes within the last 6 months; however, I place weight on the evidence within the providers response which demonstrates corrective actions had been undertaken following these incidents, prior to the site audit. Additionally, I have not been provided with evidence relating to deterioration to show these actions have not been effective in mitigating the risk.

Therefore, I find requirement (3)(d) in Standard 3 Personal and clinical care compliant.

**Requirement (3)(b)** was found non-compliant following an assessment contact undertaken in February 2024 as high impact and high prevalence risks associated with the care of each consumer were not being effectively managed. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including the implementation of resource folders for staff and delivering training in relation to recognising and responding to consumer clinical deterioration. Additionally, a high impact high prevalence risk register was implemented and is monitored and discussed at weekly multidisciplinary meetings.

At the site audit undertaken in October 2024, the high impact and high prevalence risks associated with the care of consumers were being effectively managed. Consumers expressed satisfaction with the care and services delivered and felt staff understood the risks associated with their care and these risks are effectively managed. Staff demonstrated awareness of the individual risks associated with the care of consumers and described strategies in place to mitigate the risks. Strategies to manage risks identified to consumers care, particularly in relation to falls, pressure injuries and weight loss, were in place and consistent with care documentation.

In relation to **requirements (3)(a), (3)(c)**, **(3)(e), (3)(f)** and **(3)(g),** consumers and representatives confirmed their needs and preferences were known by staff and expressed satisfaction with the personal and clinical care they receive. Consumers and representatives felt staff would support consumers at end of life, and provide palliative care in line with their needs, goals and preferences and staff would ensure comfort is maintained. Consumers and representatives described referrals are undertaken to a range of providers in a timely manner. Consumers and representatives are satisfied with the measures in place to minimise the spread of COVID-19 and other infections.

Staff described how they provide safe and effective care to consumers including delivering care and services in line with consumers goals, needs and preferences. Staff confirmed methods to communicate changes to consumers’ care and services, including through verbal handovers, care documentation, progress notes, and transfer sheets. Staff described the referral process in place and were knowledgeable about their responsibilities. Staff described process to reduce the risk of increasing resistance to antibiotics and confirmed undergoing training in the use of personal protective equipment.

Care documentation demonstrated care is provided in line with consumer’s needs, goals and preferences, with tailored interventions and strategies in place. Care documentation included timely and appropriate referrals to allied health professionals are undertaken, with recommended strategies implemented into care plans.

Processes to monitor infections and reviewing antimicrobials prescribed ensure appropriate prescribing occurs with policies, procedures and training in place to guide and support staff with infection control practices. Staff were familiar with infection control practices, which was observed through staff practices such as washing hands and using hand sanitiser before and after attending to consumers.

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

# Standard 4

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| 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

Staff are familiar with the needs, goals and preferences of consumers, and described how they tailor supports to support consumer independence and well-being. Staff described supporting consumers to participate in their community, maintain social and personal relationships and do things of interest, such as engaging external associations to enhance the lifestyle program. Staff confirmed information about consumers’ needs, choices and preferences in relation to daily living supports are documented and communicated within the service. Staff explained how consumer needs are identified and referrals undertaking, with care documentation confirming consumers are referred appropriately and in a timely manner. Staff described processes to ensure equipment is clean, maintained and suitable for use.

Consumers confirmed services and supports enable them to do what they want to enhance their quality of life, and their emotional, spiritual, and religious needs were well supported, including attending church services, functions and events. Consumers were socialising with other consumers visitors, volunteers and participating in group activities throughout the service. Consumers and representatives felt staff delivering services and supports are aware of their needs and preferences and care planning documentation included sufficient information to inform service and support needs and preferences. Consumers were satisfied with equipment provided to assist them with activities of daily living.

Care documentation outlined supports in place to meet consumers’ emotional, spiritual, and psychological needs and demonstrated supports are increased in response to changes to the consumer’s condition. Documentation and observations show consumers are provided with meals in accordance with their dietary requirements and consumers confirmed they are satisfied with the variety and quantity of food being provided at the service.

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

# Standard 5

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| 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

Consumers expressed satisfaction with their rooms and overall cleanliness of the service environment and confirmed personalising their room with personal belongings and furniture. Consumers and representatives described comfort controls and how they manage the lighting and temperature in their rooms and confirmed maintenance issues are addressed in a timely manner. Consumers can move freely throughout the facility and to outdoor areas and expressed confidence in the safety and suitability of furniture and equipment.

Staff described codes being displayed on doors for designated secure wings and assisting consumers with mobility aids to access and utilise outdoors areas. Staff described cleaning, maintenance, and monitoring processes to ensure the environment was safe and clean with hazards promptly addressed.

Furniture, fittings, and equipment were safe, clean, and maintained in line with scheduled actions. Dementia design principles were effectively used internally in the memory support units and garden areas to support consumer’s needs.

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

# Standard 6

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| 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

Consumers and representatives confirmed being supported in, and aware of mechanisms to provide feedback or make complaints, including participation in food focus groups, completing feedback forms or talking directly to staff and management. Consumers reported awareness of advocacy and language services available as well as external complaint avenues. Consumers and representatives indicated appropriate action is taken when issues are raised, and improvements made in response to suggestions or complaints.

Staff outlined actions they would take to address and escalate concerns and how they use open disclosure. Staff described the service’s incident management processes to ensure incidents are investigated and findings and outcomes are communicated to consumers, representatives and staff. Management confirmed all types of compliments and complaints are recorded to inform ongoing improvements and described how they reviewed feedback and data for trends, which are then used to develop actions for the plan for continuous improvement. Printed information on advocacy, and information on translation services and complaint services are available throughout the service and included within admission packs.

Policies and procedures are available to guide staff on how to manage complaints, encourage open disclosure and ensure best practice is followed.

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

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| 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. | Not Compliant |

Findings

This Standard is non-complaint as one of the assessed requirements is non-compliant.

**In relation to requirement (3)(e)**

The Assessment Team recommended requirement (3)(e) not met as the organisation was unable to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. The Assessment Team provided the following evidence and information relevant to my finding:

* Management did not demonstrate a process to regularly assess and review staff performance, identify skill gaps and capabilities in line with the services requirements.
* Service documentation showed performance appraisals are outstanding for 25 care staff, with no clinical staff or hospitality staff having a recent performance appraisal.
* Management acknowledged deficits in completion of staff performance appraisals and competency assessments, and explained this is due to competing priorities and organisational changes.

The provider did not agree with the assessment team’s recommendations and provided the following information within their response relevant to my finding.

* The provider asserts all performance appraisals have been scheduled, with a planned approach to have all staff completed by the end of June 2025. The plan for continuous improvement indicates 40% of staff are still outstanding for an annual performance appraisal.
* The provider described monitoring of staff performance occurs through direct manager supervision, work rounds, observations, attending handovers, consumer feedback and investigation of data such as incidents. Additionally ongoing feedback mechanisms are in place for staff through, staff surveys, questionnaires, supervisory sessions and peer reviews.
* The provider asserts individualised supportive improvement plans are developed and implemented for staff when required.

I acknowledge the information included in the providers response; however, I find the service does not currently undertake regular assessments of the performance of each member of the workforce. In coming to my finding, I have considered, and placed weight on the intent of the requirement where all members of the workforce are expected to have an appropriate person regularly evaluate how they are performing their role, and identify, plan for and support any training, and development they need. I have considered evidence within the Assessment Team’s report, and providers response which indicates 40% of the workforce is still outstanding for a performance appraisal. I have also considered that while the response indicates a plan to ensure appraisals are caught up, the provided plan for continuous improvement will require time to be fully implemented and evaluated for effectiveness, with a planned completion date of March 2025.

Therefore, I find requirement (3)(e) in Standard 7 Human resources non-compliant.

**Requirement (3)(c)** was found non-compliant following an assessment contact undertaken in February 2024 as the service did not ensure the workforce was competent and have sufficient knowledge to undertake their roles effectively.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including implementation of resource folders and training packs in relation to mandatory reporting, restrictive practices and standard operating procedures. Additionally, the clinical government team increased oversight through monthly meetings to review high impact high prevalence risks and analysis of monthly quality indicators.

At the site audit undertaken in October 2024, the service demonstrated the workforce is competent and have sufficient knowledge to undertake their roles effectively. Consumers and representatives confirmed staff are competent and able to meet the needs of consumers’. Staff described training and competency assessments undertaken to enable them effectively to perform their roles. Service documentation shows staff have the necessary competencies, skills and knowledge required to effectively perform their roles. Training records demonstrate staff complete various training sessions focused on the Quality Standards, including cultural diversity, inclusive care concepts and prevention of elder abuse.

Based on the Assessment Team’s report, I find requirement (3)(c) in Standard 7 Human resources compliant.

**In relation to requirements (3)(a), (3)(b) and (3)(d),** consumers and representatives confirmed the service delivers care and services as planned and staff interactions are kind, caring, and respectful. While one consumer indicated staffing numbers at night may be a concern in an emergency response given the layout of the building, most consumers were satisfied with the number and mix of staff, and no adverse events were recorded due to overnight staffing. Consumers and representatives expressed confidence in the ability of staff delivering care and services to consumers.

Staff interactions are supportive, respectful and kind, and staff confirmed onboarding and training programs to ensure they have adequate knowledge to perform their roles. Staff confirmed undertaking induction and onboarding processes, which included mandatory training modules and buddy shifts.

Management described recruitment processes to include pre-screening of the skills, qualifications and documentation of staff files showed required registrations and checks and described the current recruitment process for clinical and housekeeping positions. Management described how the multidisciplinary team meetings oversee rostering arrangements and confirmed feedback and complaints data is reviewed to identify any concerns with staff and consumer interactions and would respond accordingly if concerns are identified.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(b) and (3)(d) in Standard 7 Human resources compliant

# Standard 8

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| 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. | Not Compliant |

**Findings**

This Standard is non-compliant and one of the assessed requirements is non-compliant.

**In relation to requirement (3)(e)**

The Assessment Team recommended requirement (3)(e) not met as they were not satisfied clinical governance processes in relation to the minimisation of restrictive practices was demonstrated.

The Assessment Team provided the following evidence and information relevant to my finding:

* Care documentation for 6 sampled consumers showed only 3 had psychotropic prescription rationale forms completed. The 3 sampled forms stated the psychotropic medications prescribed do not modify the consumers behaviour.
* Care documentation and the service’s psychotropic register for sampled consumers showed medications were used for the purpose of influencing the consumers behaviour.
* For one named consumer, prescribed both regular and as required antipsychotic medications, only the as required medication had been identified as a restrictive practice.
* The psychotropic self-assessment for the service did not capture ongoing informed consent, with sampled consumers only documenting consent at initial prescribing.
* Behaviour support plans for 6 sampled consumers did not include all relevant information in line with legislative requirements, particularly in relation to restrictive practices.

The provider did not agree with the Assessment Team’s recommendations and provided the following information and evidence relevant to my finding.

* The provider confirmed the psychotropic prescription rational form is no longer in use as all psychotropic medications are documented in the electronic medication management system.
* The provider asserted only one out of the 6 named consumers is prescribed psychotropic medication as a chemical restraint. For the named consumer the provider asserts both regular and as required psychotropic medications were identified as chemical restraint.
* The provider asserted consent is managed through the electronic medication management system, where the medical officer is responsible for obtaining consent and documenting in the psychotropic self-assessment. The system will not allow re-prescribing unless this information is entered.
* The psychotropic self-assessment form provided included all consumers on psychotropic, or high risk medications.
* For the named consumer, the psychotropic self-assessment did not indicate the regular psychotropic medication was a chemical restraint. Additionally, the psychotropic medication was last reviewed on the 30 October 2024, however the consent was last obtained on the 27 February 2024.
* Additionally, a further 2 consumers prescribed regular psychotropic medication were not identified as chemical restraint. One consumer was prescribed medication for the management of Alzheimer’s dementia with anxiety symptoms was not identified as a chemical restraint, and the second prescribed medication for disinhibited behaviour.
* An additional consumer identified on the psychotropic self-assessment as subject to chemical restraint, last had a formal medication review on the 29 November 2024, however, consent was last recorded as being obtained on the 30 June 2023.
* The provider asserted for named consumers, only one consumer is subject to chemical restraint, and the provider is confident the behaviour support plan meets legislative requirements and provided the consumer’s care plan, including behaviour support plan.
* The behaviour support plan for the named consumer included generic interventions, such as providing familiar objects, physical, occupational and recreational therapies, staff interaction and structured routine. Additionally, the indication for restrictive practices on the behaviour support plan is calling out all day, causing herself and others distress, with triggers identified as fear and confusion. The behaviour support plan does not include any personalised information on the consumer past life and background to assist in supporting the consumer.

I acknowledge the providers response; however, I find the organisation does not have an effective monitoring system in place to ensure restrictive practices, particularly chemical restraints, are identified correctly, with informed consent obtained and reviewed on a regular basis and behaviour support plans which inform tailored support is provided minimising the use of restrictive practices. In coming to my finding, I have considered and placed weight on the additional evidence included in the providers response, particularly the psychotropic self-assessment. While the provider asserts all consumers are correctly identified as being subject to restrictive practices, with consents reviewed when medications are reviewed by the medical practitioner, the psychotropic self-assessment showed there are deficiencies in this process, with an additional 3 consumers identified through review. Additionally, the behaviour support plan provided for the named consumer did not include tailored strategies to assist in supporting the consumer and reducing the need for restrictive practices.

Therefore, I find requirement (3)(e) in Standard 8 Organisational Governance non-compliant.

**Requirement (3)(d)** was found non-compliant following an assessment contact undertaken in February 2024 as the service was not undertaking incident reporting and investigation, including open disclosure in line with the organisation’s processes. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including implementing a root cause analysis tracker, which is discussed at clinical analysis team meetings. Additionally, an audit process was established for the incident management system with training provided to clinical managers.

At the site audit undertaken in October 2024, the organisation demonstrated effective risk management systems are in place to identify and mitigate consumer risks, including through the use of an incident management system. Policies, procedures and training inform staff practice on managing high-impact or high-prevalence risks, reporting incidents of abuse and supporting consumers to live their best live. Monitoring processes, such as audits, clinical indicators and risk meetings, are in place to ensure compliance. Consumers and representatives expressed satisfaction with the services response when incidents occur and described feeling comfortable with how the service balances risks and quality of life.

Based on the Assessment Team’s report, I find requirement (3)(d) in Standard 8 Organisational governance compliant.

**In relation to requirements (3)(a), (3)(b) and (3)(c),** consumers and representatives confirmed they are engaged and supported in the development of care and services through various mechanisms. Consumers and representative expressed confidence in the way the service was being managed. Service documentation confirmed engagement of consumers, including through meeting minutes from the consumer advisory body, surveys and consultations.

An organisational structure and framework is in place which includes the delegation of roles, responsibilities and accountabilities. The organisation is governed by a board who are responsible for the governance and the organisation’s strategic direction and is supported by various committees and sub-committees. Board meeting minutes show reports from sub-committees, such as clinical governance, are reviewed and discussed.

The organisation has effective organisational wide systems including information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Staff demonstrated an understanding of organisational governance systems and confirmed access to relevant information to guide them on delivering care and services. Financial performance reports are regularly reviewed by the governing body, with legislative updated provided by peak bodies. Workforce governance systems and process to ensure workforce arrangements such as staff rostering and credentialling and feedback mechanisms are in place. Continuous improvement plans are maintained, reviewed and consumer focused, and regulatory compliance requirements are monitored through monthly reports, audits and performance monitoring.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(b) and (3)(c) 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)