Performance

Report

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| Name of service: | Bethanie Dalyellup |
| Service address: | 114 Norton Promenade DALYELLUP WA 6230 |
| Commission ID: | 8226 |
| Approved provider: | The Bethanie Group Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 July 2023 to 20 July 2023 |
| Performance report date: | 12 September 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 Bethanie Dalyellup (**the service**) has been prepared by M Dubovinsky, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the Approved Provider’s response to the Assessment Team’s report received 11 August 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 7** **Human resources** | **Not applicable as not all requirements have been assessed** |
| **Standard 8** **Organisational governance** | **Non-compliant** |

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

# Areas for improvement

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

* Review the clinical governance framework and relevant and policies and procedures specifically in relation to minimising the use of restraint. Ensure policies and procedures in relation to restrictive practices and behaviour support are in accordance with the *Quality of Care Principles 2014.*
* Ensure staff are trained and using relevant policies and procedures in relation to restrictive practices and recognise and minimise the use of restraint within the service.
* Ensure restraint usage within the service and organisation is monitored and minimised.
* Ensure the clinical governance framework supports effective assessment and planning in the context of restrictive practices and behaviour support.

# 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 |

Findings

The Assessment Team recommended Requirement (3)(a) met. The service has recently commenced and was able to demonstrate assessment and planning being undertaken for consumers sampled to inform the delivery of safe and effective care and services. The following evidence was considered relevant to my finding;

* Documentation showed a clinical admission checklist is commenced at pre-admission and a detailed interim care plan is created on admission. However, not all documentation was completed with 10 of 15 consumer profile pages not completed. Management said they were aware and had adjusted the staffing and the number of consumers entering the service to support effective assessment and planning.
* Three consumers sampled had a range of assessments completed including in relation to skin, oxygen therapy and medications with relevant strategies developed.
* One consumer and one representative confirmed being involved in the assessment process and were satisfied with the provision of care and services.
* Management described a planned approach for consumers entering the service to support effective assessment.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers 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 |

Findings

The Assessment Team recommended Requirement (3)(a) met. The service demonstrated the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. The following evidence was considered relevant to my finding;

* Evidence documented in Standard 2 Requirement (3)(a) showed consumers were satisfied with the provision of care and services. However, one consumer and representative stated they felt the service was understaffed to provide care and services according to consumer preferences and clinical needs.
* The Assessment Team observed care being undertaken and observed carers supporting consumers for their daily living in a respectful unrushed manner.
* Clinical and care staff interviewed said there were sufficient staff to provide clinical care.
* Allocation sheets showed unfilled shifts were filled with agency staff and Registered Nursing staff were onsite for the entire 24-hour period.
* The service has planned staffing levels of one care worker for 6 consumers and has practices in place to review target levels based on the acuity of consumers.

For the reasons detailed above, I find Requirement (3)(a) in Standard 7 Human resources complaint.

# 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. | 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

I have assessed the Quality Standard as non-compliant as I am satisfied Requirement (3)(e) is non-compliant.

Requirement (3)(e)

The Assessment Team recommended Requirement (3)(e) in Standard 8 not met. The service was not able to demonstrate an effective clinical governance framework specifically in relation to minimising the use of chemical and mechanical restraint. Whilst the service has policies and procedures regarding restrictive practices, the framework did not ensure these policies and procedures were effectively followed to minimise the use of restraint within the service. The following evidence was considered relevant to my finding;

* The service has policies and procedures in relation to chemical, environmental and physical restraint and management reported no consumers at the service are subject to chemical restraint.
* Consumer A is prescribed as required psychotropic medication with an administration in the month prior to the Assessment Contact. The behaviour care plan shows the consumer is administered psychotropic medication to manage their condition and the plan states it is not a restrictive practice. The representative stated they requested the medication as the consumer was unsettled and frequently upset.
* Consumers B, C, D and E are prescribed regular and/or as required psychotropic medication in the form of chemical restraint for the management of changed behaviours.
* Consumer J was observed to be mechanically restrained whilst in bed with their bed positioned to the lowest position, despite staff stating the consumer ambulates from the bed to the chair and is unable to get out of bed by themselves when at the lowest position. Staff stated the consumer had requested to have their bed positioned to the lowest position to support a spiritual activity they partake in. Documentation viewed did not show preferences, risks and strategies were developed or considered.
* The service was unable to demonstrate a record of informed consent had been obtained for consumers in relation to the psychotropic medication being administered in the form of chemical restraint.
* Consumers F, G, H and I are prescribed and administered regular psychotropic medication. However, the service has not recognised the medication being used in the form of chemical restraint.
* A response was not provided in relation to Consumer A.
* The service has a range of quick reference guides to inform staff practice on a range of clinical areas other than restrictive practices.
* In relation to antimicrobial stewardship, staff were able to describe how they apply infection control practices and implementing non-pharmacological strategies to minimise risks of infections.
* In relation to open disclosure, the organisation has an open disclosure policy and procedure, and staff were able to describe open disclosure practices.

The Approved Provider’s response agrees with some of the Assessment Team’s findings and has submitted a plan for continuous improvement. The following evidence was considered relevant to my finding.

* A plan for continuous improvements was included which outlined a range of improvements which are scheduled. Improvements included developing a quick reference guide for staff in relation to restrictive practices, training for all staff on restrictive practices, development of an approved diagnosis list and a review of processes to support the consideration of psychotropic medications as a restrictive practice.
* Accepted the findings for Consumers F, G, H and I in relation to the medication being used as a form of chemical restraint which was not recognised. In addition, the findings for Consumer J were accepted in relation to mechanical restraint in the context of positioning the bed height in a manner which restrict freedom of movement. Staff were subsequently instructed not to leave the beds at the lowest height unless a relevant restrictive practice consent was developed, and relevant care planning completed.
* The response did not directly respond to Consumer A and stated Consumers B, C, D, E are not chemically restrained as they have a relevant diagnosis. A range of supplementary information was provided, however it is unclear from the information provided if the medication is being used to treat the condition or changed behaviours.

I acknowledge the Approved Provider’s response including the plan for continuous improvement and additional information provided. Based on the Assessment Team’s report and Approved Provider’s response, I find the service was not able to demonstrate an effective clinical governance framework specifically in relation to recognising and minimising the use of restraint. Whilst the service has policies and procedures in relation to restrictive practices, they were not able to demonstrate their systems and processes were effective in restraint minimisation within the service. I find the service was able to demonstrate an effective clinical governance framework in relation to antimicrobial stewardship and open disclosure.

In coming to my finding, I have considered the intent of the requirement being safe systems to support the delivery of safe and quality clinical care and specifically in the context of behaviour support and restraint minimisation. I find, whilst the service had policies and procedures in relation to restrictive practices and behaviour support, this did not ensure restrictive practices were identified for all consumers at the service and restrictive practices minimised.

I acknowledge the Approved Provider has accepted the findings for Consumers F, G, H, I and J as being a form of restrictive practice in the form of chemical and mechanical restraint.

Whilst I acknowledge, the approved provider asserts Consumers B, C, D, E had a relevant diagnosis and were not chemically restrained, I am not satisfied sufficient evidence was presented to demonstrated organisational systems and processes through clinical governance ensured appropriate and relevant consideration for the medication being prescribed and administered in the context of a potential chemical restraint. In relation to Consumer A, the evidence indicates the medication is being used to influence the consumer’s changed behaviour.

In coming to my finding, I have considered the responsibilities of Approved Providers in relation to behaviour support and restrictive practices as outlined in the *Quality of Care Principles 2014* and specifically in relation to restrictive practices being as least restrictive, obtaining records of informed consent and ensuring relevant assessment and planning is undertaken to support effective use of restrictive practices. I have considered the integral role of effective clinical governance as critical in the implementation of safe and quality care and services.

I acknowledge the Approved Provider’s proactive measures following the Assessment Contact with a range of improvements commenced during the Assessment Contact and following.

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

Requirement (3)(d)

The Assessment Team recommended Requirement (3)(d) met and was able to demonstrate effective risk-based systems and practices. The following evidence was considered relevant to my finding;

* In relation to managing high-impact or high-prevalence risks associated with the care of consumers, the service has policies and procedures in place to assist and guide staff. Clinical indicators are reviewed at the Clinical Governance monthly meeting and by the senior clinical staff for improvement opportunities.
* In relation to identifying and responding to abuse and neglect of consumers, the service has policies and procedures in place to assist staff in identifying and responding to incidents of abuse and neglect of consumers. Documentation viewed sampled demonstrated, staff and identifying and report incidents.
* In relation to supporting consumers to live the best life they can, processes support staff in undertakes relevant assessments to inform consumers and representatives and mitigate potential risks. However, for one consumer relevant assessment had not been documented including risks assessed in relation to the consumer’s low bed height and potential risks which was considered in Requirement (3)(e) in this Standard.
* In relation to managing and preventing incidents, including the use of an incident management system, incidents are recorded and reviewed with mitigating strategies developed. Audits are undertaken on incident data to identify opportunities for improvement with recent improvements commenced in relation to falls management.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance compliant.

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