Performance

Report

**1800 951 822**

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| Name of service: | Boandik St Mary's |
| Service address: | 71 Boandik Terrace MOUNT GAMBIER SA 5290 |
| Commission ID: | 6234 |
| Approved provider: | Boandik Lodge Inc |
| Activity type: | Site Audit |
| Activity date: | 4 July 2023 to 6 July 2023 |
| Performance report date: | 25 August 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 Boandik St Mary's (**the service**) has been prepared by R Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Assessment Team’s report received 3 August 2023.

# Assessment summary

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

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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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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.

Standard 3 Requirement (3)(a)

* Ensure each consumer receives safe and effective personal and clinical care, specifically in relation to continence care.

Standard 5 Requirement (3)(b)

* Ensure the environment is safe, clean and well maintained specifically in relation to the memory support unit.

Standard 7 Requirement (3)(c)

* Ensure the workforce is competent and have the knowledge and qualifications to perform their roles effectively, specifically in relation to managing clinical risks, including falls and deterioration, and understanding restrictive practices.

Standard 8 Requirement (3)(d)

* Ensure the organisation has effective governance systems, specifically in relation to workforce governance and feedback and complaints.

# 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

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 28 September 2021 to 30 September 2021 where it was found each consumer was not treated with dignity and respect, with their identity, culture and diversity valued. Staff interactions with consumers were not consistently kind and respectful and consumers’ dignity and privacy were not always maintained.

The Assessment Team’s report included several actions the service has taken to address the deficits identified at the Site Audit, including, but not limited to:

* Staff education around customer service, dignity of choice and care planning.
* An all-staff memo issued in relation to organisation’s code of conduct.
* A reminder added to the resident and relative agenda to ensure consumers know they can provide feedback or make complaints at any time directly to the manager.

At the Site Audit visit conducted 4 July 2023 to 6 July 2023, the Assessment Team were satisfied consumers were treated with dignity and respect and found requirement (3)(a) met.

Consumers and representatives confirmed staff treat consumers with dignity and respect when delivering care and services. Consumers confirmed they are supported to make choices over the way their care and services are delivered and who they wish to be involved in their care and those decisions are respected. Consumers confirmed their privacy is respected and maintained by staff and they are confident their personal information is kept confidential.

Consumers and representatives confirmed consumers can take risks and are supported to do so to live their best life. Consumers confirmed where they take risks, they are discussed with staff to preserve their safety. Documentation reflected consumer choice and where risks were taken, a Dignity of risk and/or risk assessment has been completed with strategies to mitigate the risk of harm to consumers.

Observations showed staff interacting with consumers in a respectful manner, maintaining consumer privacy and dignity when delivering care and information was kept confidential through password protected electronic care systems.

Staff could demonstrate how they engage consumers in making choices about their care and services and how they support them to take risks they wish to take. Staff confirmed they assist consumers to understand information provided, and how they ensure consumers’ privacy is respected and personal information is kept confidential.

Documentation reflected consumers’ choice and consultation of risks where appropriate, and information provided to consumers is done so in an appropriate, accurate and timely manner.

Based on the information above, I find Standard 1 Consumer dignity and choice 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

Requirements (3)(e) was found non-compliant following a Site Audit undertaken from 28 September 2021 to 30 September 2021 consumer care plan reviews were not completed at regular intervals or when changes or incidents including falls occur.

The Assessment Team’s report included several actions the service has taken to address the deficits identified at the Site Audit, including, but not limited to:

* Implementation of a Dignity of risk policy.
* A review of all consumers’ care plans to ensure consideration of risk is included.
* Daily progress note review by the clinical nurse commenced.
* Implementation of a high-risk register.
* Two registered nurses allocated to provided training to clinical staff.

At the Site Audit, the Assessment Team recommended requirements (3)(b) and (3)(e) not met as they found consumer care plans did not include strategies and interventions to guide staff practice, staff were not knowledgeable of the needs, goals and preferences of consumers in relation to activities of daily living and consumer care plans were not reviewed or updated following change in circumstances, including deterioration in health or following a return from hospital. I have come to a different view to the Assessment Team for requirements (3)(b) and (3)(e) and include my reasons for that below.

**Requirement (3)(b)**

The Assessment Team’s report included the following information and evidence gathered via interview, observation and documentation relevant to their recommendation:

* Documentation confirmed three consumers (Consumers A, B and C) had been self-showering for the week preceding the Site Audit visit and care plans confirm all three consumers require staff assistance for activities of daily living.
* Consumer D’s representative confirmed they requested additional toileting assistance; however, Consumer D’s care planning was not reflective of this.
* Three consumers did not have a social well-being assessment undertaken since admission which was identified as more than 4 months and one consumer’s assessments and care planning was not reflective of their current needs, including for diabetic, continence and pain management, nutrition, pain and sleep.
* End of life assessments for two consumers were not completed with personal goals or wishes prior to them entering an end-of-life pathway.

The provider acknowledged the findings in the Assessment Team’s report in relation to the social well-being and end of life (EOL) assessments for consumers sampled not being completed and provided a plan of continuous improvement with actions to address the deficits identified including:

* Education delivered to clinical staff to ensure when consumer care needs change the care plan is updated in a timely manner.
* Undertaken an audit of all consumer care plans to ensure up to date and accurately reflect consumer needs and goals, including EOL planning.
* Review of the organisation’s assessment and planning policies and procedures.

I acknowledge the information included in the Assessment Team’s report; however, I have come to a different view to that of the Assessment Team and find that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences. In coming to my finding, I have considered information in the Assessment Team’s report that shows EOL assessments may not have been current for two consumers and social well-being assessments not completed for three consumers. However, I acknowledge the provider’s response that iterates staff were aware of the needs of consumers and delivered care in a way that met those needs and have considered the additional information included. In relation to the EOL assessment, the provider asserts staff were knowledgeable of the needs of both consumers sampled and delivered care that maximised the comfort of each during this time. The provider’s response includes documentation that shows the families of both consumers were thankful for the care delivered to the consumers during their EOL stage.

I have also considered the additional information in the provider’s response that shows assessment and planning for most consumers sampled in the Assessment Team’s report identifies the current needs of those consumers. In relation to Consumers A, B, C and D, the provider does not agree with the information included in the Assessment Team’s report around assessment and planning not being current and asserts Consumers A, B and C frequently refuse assistance with activities of daily living, Consumer C’s assessment and planning includes their current needs and goals, and provided the following additional information and commentary:

* Hygiene and presentation assessments for Consumers A and C. Consumer A’s hygiene assessment records they require staff supervision and provision of verbal and/or physical assistance for washing and drying and one staff supervision with showering due to mild cognitive impairment. The assessment also records Consumer A may decline assistance from staff with personal hygiene. Both assessments are dated within 6 weeks of the Site Audit visit from Consumer A is 17 May 2023 and Consumer C is 1 July 2023.
* Consumer B’s hygiene and presentation assessment records they require one staff assist with washing, drying and grooming activities due to poor eyesight and records Consumer B likes to shower themselves as their goal is to maintain independence and will often refuse assistance. The assessment includes strategies of staff to assist and where refusal of assistance to discreetly ensure safety and dated as at 30 June 2023.
* Consumer C’s hygiene and presentation assessment records they require one staff assist with washing and drying activities, that Consumer C verbally denies assistance with showering/dressing and grooming and directs staff to encourage Consumer C to accept assistance to maximise safety.
* Behaviour assessment management plans for all three consumers that documents they can refuse assistance and provides strategies, including to encourage assistance and discreetly check on each consumer to ensure safety.
* Consumer C’s Respite assessment support plan last updated on 6 June 2023 that includes Consumer C’s needs and preferences for sleep, rest, personal hygiene, mobility, pressure area care and pain management. The provider asserts the information about Consumer C’s diabetic management is incomplete and not containing blood glucose level (BGL) parameters due to the medical officer they had being private and deciding not to provide care when Consumer C moved to the service of which they have already rectified and referred Consumer C to a different medical officer.
* The provider’s response includes Consumer D’s current Bowel and urinary assessment and management, completed on 10 December 2022 which includes information about continence care, including toileting regime.

In coming to my finding, I have placed weight on the additional information the provider has included in their response that shows for Consumers A, B, C and D, assessment and planning was current and included their needs, goals and preferences for the delivery of care and services. I have also placed weight on the actions taken by the provider immediately following the Site Audit visit to rectify the deficits in assessment and planning identified by the Assessment Team.

Based on the information above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers compliant.

**Requirement (3)(e)**

The Assessment Team’s report included the following information and evidence gathered via interview, observation and documentation relevant to their recommendation:

* Consumer E had 15kg weight loss in 2 months and was reviewed by a Dietician on 21 June 2023 with recommendations, including soft bite sized food, mildly thickened fluids and two varieties of supplements, however, the nutrition assessment was not reviewed or updated to include those recommendations. Consumer E’s nutrition assessment was not updated to include the recommendations until 4 July 2023 after the Assessment Team provided feedback.
* Consumer F’s mobility assessment completed on 18 April 2023 stated a bed alarm was in place due to wandering, however, staff confirmed Consumer F’s bed was in the lowest position to reduce their falls. The Assessment Team did not identify a restraint assessment completed for the use of low low bed. Management confirmed Consumer F could no longer weight bear and did not wander into other consumers’ rooms. The mobility assessment did not reflect the updated information about Consumer F’s condition.
* Consumer G’s behaviour support plan was not reviewed or updated post a hospital transfer when a change in mobility occurred and Consumer G no longer was weight bearing and wandering into other consumers’ rooms.
* Two consumers, including Consumer C, who require visual monitoring did not have monitoring charts completed consistently and both sustained unwitnessed falls. Consumer C had 11 falls in a 13-day period from 22 June 2023 to 4 July 2023.
* Signing sheets were not completed for two consumers who receive nutritional supplements and staff were unable to confirm if those had been provided to those consumers as per recommendations.
* Management issued a memorandum to all staff following feedback from the Assessment Team to indicate charting will be monitored to ensure they are completed.

The provider acknowledged the deficits identified in the Assessment Team’s report in relation to the updating of mobility assessment and behaviour support plans for Consumers F and G following changes in their mobility and included actions taken immediately following the Site Audit, including updating care plans of sampled consumers and planned actions, including a revised return from hospital procedure. However, the provider did not agree with the findings in the Assessment Team’s report in relation to Consumers E and F and provided the following commentary and additional information in their response:

* Consumer E’s weight loss was as a result of a diuretic medication prescribed by the medical officer and a positive fluid shift.
* Documentation that shows nutritional supplements have been consistently provided and are recorded through the service’s electronic medication management system.
* A risk assessment for Consumer E was completed 28 March 2023 after an incident where they choked on some food. The risk assessment includes Consumer E’s wish to eat foods of their choice and the risks associated, including the risk of choking with the consumer’s signature noted.

I acknowledge the information in the Assessment Team’s report and have balanced that against the additional information included in the provider’s response and have come to a different view to that of the Assessment Team and find the service has demonstrated it reviews assessments when there is a change in condition or incidents occur. In coming to my finding, I have placed weight on the documentation included in the provider’s response for Consumer E that shows the nutrition assessment was reviewed and a risk assessment completed when an incident occurred in March 2023 that identified possible risks of choking. I have considered for Consumer E, documentation in the provider’s response shows nutritional supplements have been administered consistently.

In relation to Consumers F and G, the provider asserts the service took actions to address the inaccuracy in information and updated both mobility assessments at the time of the Site Audit and further actions immediately following the visit to review the behaviour support plans and update with current information following changes in mobility. I have considered information that shows the service had completed an annual review of almost all consumer care plans at the time of the Site Audit. I have also considered the actions included in the plan for continuous improvement that includes a review of care plans and education to clinical staff about reviewing the current needs and goals of consumers when a change or incident occurs.

Based on the reasons above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

In relation to requirements (3)(a), (3)(c) and (3)(d), consumers and representatives confirmed they are partners in the development of consumers’ care and services and confident those are developed with the consideration of risks to their health and well-being. Consumers were satisfied their care needs and preferences were communicated appropriately and confirmed they did not have to repeat those to other providers of care.

Staff demonstrated knowledge of consumers’ needs, goals and preferences for care and described the ways in which their delivered care in a way that meets consumers’ individual preferences. Staff confirmed information is communicated to them about consumer care and services at the commencement of each shift through handover and they have access to care plans to familiarise themselves with consumers’ care needs.

Consumers’ care documentation confirmed assessment and planning is completed with the consideration of risks, including falls, diabetes, and behaviour management. Care plans reflected consumers and representatives are consulted in their development.

Based on the reasons above, I find requirements (3)(a), (3)(c), and (3)(d) in Standard 2 Ongoing assessment and planning with consumers 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. | Non-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

Requirements (3)(a) was found non-compliant following a Site Audit undertaken from 28 September 2021 to 30 September 2021 where it was found safe and effective care was not provided in relation to restrictive practices, catheter, and wound care.

The Assessment Team’s report included several actions the service has taken to address the deficits identified at the Site Audit, including, but not limited to:

* Implementation of new wound management policies and training delivered to staff around wound care.
* Implementation of a falls risk and management policy with ongoing education at the monthly clinical meetings.
* A folder for referrals to the speech pathologist and dietician to monitor and ensure referrals are actioned.
* Toolbox training in relation to incontinence associated dermatitis (IAD).
* A monthly review of psychotropic medication usage.
* Behaviour management training provided in one-on-one sessions with staff by an external dementia specialist.

At the Site Audit, the Assessment Team recommended requirements (3)(a) and (3)(b) not met as they found consumers did not receive safe and effective best practice care tailored to the needs in relation to the management of wounds, diabetes, vital signs monitoring and personal care. The service could not demonstrate effective management of high impact or high prevalent risks to consumers, including restrictive practices, behaviours, incidents and falls.

**Requirement (3)(a)**

The Assessment Team’s report included the following information and evidence gathered via interview, observation and documentation relevant to my finding:

* Two consumers with insulin dependent diabetes requiring regular and sliding scale insulin were identified with multiple medication errors.
* Consumer H was prescribed sliding scale insulin in November 2022 and on two occasions between 11 and 24 June 2023 staff did not follow medical officer directives and administered incorrect dosages of insulin. On both occasions following feedback from the Assessment Team an incident report was completed form the medication error.
* Consumer I was prescribed sliding scale insulin in August 2021 and on two occasions in June 2023 staff did not follow medical officer directives and administered incorrect dosages of insulin. On both occasions following feedback from the Assessment Team an incident report was completed form the medication error.
* Vital signs were not consistently recorded in relation to blood pressure and weight monitoring for Consumer J and staff did not follow directives of daily blood pressure and weekly weight monitoring. The Assessment Team identified between 6 June 2023 and 3 July 2023 there were 14 days where vital chart was not competed.
* Wound charting for two consumers (Consumers E and J) were inconsistent and measurements were not recording accurately, photographs did not have measurements and pressure injuries misclassified by staff.
* Consumer E was identified with stage 2 pressure injury with sizes recorded between 19 and 22 April 2023 inconsistent as staff recorded a smaller wound size on 22 April 2023 than was recorded on 19 April and then larger the following day 23 April 2023. Photographs of the wound did not show measurements and on 2 July 2023, the wound had again increased in size. Clinical staff confirmed Consumer E had not been referred to an external wound specialist.
* Management confirmed Consumer E’s wound was not a pressure injury and was IAD.
* Consumer K was identified with a stage 2 pressure wounds acquired outside the service. Wound charts showed inconsistent wound measurements, in March 2023 the wound was measured and had increased in size, but staff downgraded the classification to stage 1 pressure wound. Photographs did not show measurements and staff confirmed Consumer K had not been referred to an external wound specialist for review.
* Management confirmed the wound appeared to be an IAD and not a pressure wound.

The provider acknowledges the deficits identified in the Assessment Team’s report in relation to diabetes management for Consumers H and I, and vital signs charting for Consumer J and provided actions to address those in their response, including, but not limited to:

* Staff involved in inaccurate insulin administration stood down from administering until competency is again established.
* Review of the service’s Diabetes management policy and procedure.
* Face to face education on diabetes management with an external specialist.
* Education provided to staff undertaking blood glucose monitoring testing.
* Review of Consumer J’s blood pressure and weight readings to ensure all strategies and interventions are transferred to their specialised nursing care plan.

The provider disagreed with some information in the Assessment Team’s report in relation to wound care and makes an assertion that management did not recall discussions of pressure wounds being incorrectly classified and were IADs. However, the provider’s response also includes actions in their plan for continuous improvement for wound care, including an audit of all consumers assessed with an IAD, education for clinical and care staff around assessment and management of pressure injuries and IAD.

I acknowledge the information in the provider’s response, including the actions they have developed and undertaken to address the deficits identified. However, I find the service was unable to demonstrate personal and clinical care is safe and effective, best practice, tailored to consumers or optimises their health and well-being. In coming to my finding, I have considered for Consumers H and I, diabetes management was not done in line with best practice and not optimal for their health and well-being where staff did not follow diabetic management directives from the medical officer and administered incorrect doses of insulin. Furthermore, the service’s incident management system did not identify a medication error had occurred until the issue was identified by the Assessment Team, of which I have considered this in Standard 8 requirement (3)(d). I have also considered for Consumer J, the monitoring of vital signs, including blood pressure and weights were not done in accordance with their specialised nursing needs posing risks to their health and well-being.

I acknowledge the provider has a plan for continuous improvement and has implemented actions to address the deficits but find those actions will need further time to be fully embedded.

Based on the reasons above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The Assessment Team’s report included the following information and evidence gathered via interview, observation and documentation relevant to my finding:

* Two consumers (Consumers F and L) were identified with low low beds with no mechanical restraint authorisations in place. The mobility assessments for both consumers records they can mobilise.
* Management confirmed Consumer F was no longer weight bearing and the bed was not a restraint, and Consumer L should not have their bed in a low position.
* Behaviour charting for three consumers (Consumers G, M and N) did not demonstrate individualised strategies to manage behaviours.
* Consumer G was transferred to the service from hospital in June 2023 for behaviour management and were unable to weight bear, but their behaviour support plan was not updated to reflect this information.
* Two clinical staff advised Consumer G does not require behaviour management strategies as they are now wheelchair bound.
* Progress notes between 19 June 2023 and 3 July 2023 confirm Consumer G is resistive to care, physically agitated and kicks staff during personal care.
* Handover sheets on 28 June 2023 record Consumer G as punching staff, no incident report was completed but a progress note with this information was documented by clinical staff.
* Behaviour charting completed between 18 June 2023 and 3 July 2023 records 11 occasions where Consumer G had incidents of physical aggressions and resistive to care towards staff.
* Consumer M’s representative attends the service daily to assist with personal care as they are resistive to staff assistance. Behaviour charting between February 2023 and July 2023 recorded 36 occasions where Consumer M has had verbal aggression towards staff.
* Staff confirmed Consumer M can become loud and abusive towards staff during personal care and stated interventions are to redirect or leave them alone and return later.
* Behaviour charting records on multiple occasions Consumer M as being agitated, aggressive, angry or abusive. No incident reports were noted or reviews of Consumer M’s behaviour support plan, with generic interventions recorded to guide staff, including likes to stand in shower, talk to gain trust and staff to intervene.
* Consumer N is identified as having wandering behaviours with an incident recorded on 2 June 2023 where they entered a room of two female consumers during the night waking and frightening them both. Consumer N’s care documentation records this occurs frequently. Consumer N’s interventions are recorded as only redirection which has not been effective as the behaviour is ongoing. Staff confirmed they have implemented barriers in the doorways of consumers’ rooms Consumer N goes into at night but have not reviewed the behaviour strategies for Consumer N.
* Falls management has not been effective for Consumer C who sustained 11 falls over a 13-day period (22 June 2023 to 5 July 2023), 7 of those unwitnessed. Investigations were not initiated or undertaken in a timely manner and Consumer C sustained 9 falls prior to any evaluation of falls prevention occurred by staff. Monitoring of Consumer C post fall has been inconsistent and not in line with the falls risk assessment for them.
* Staff did not undertake neurological observations in line with service policy and procedures and over the 13-day period where 11 falls occurred Consumer C’s observations were taken only 60 of a possible 143 times and 30 minutes post fall not 15 minutes as per policy.
* Consumer C’s blood pressure was not consistently recorded during this time and on two occasions, Consumer C experienced rapid decrease in their blood pressure readings and no additional monitoring occurred.

The provider acknowledged the Assessment Team’s report and disagreed with the findings and has provided the following additional information and commentary:

* In relation to Consumers F and L, the provider asserts both consumers are non-ambulant and, as such their beds in the lowest position are not a mechanical restraint.
* In relation to Consumers G, M and N the provider asserts each of their behaviour management plans are individualised and included those which record detailed interventions for each consumer. Consumers G and M’s behaviour support plans were last updated in February 2023 and June 2023 and Consumer N July 2023, with triggers to behaviours listed and strategies to manage each of those that are personalised to each consumer.
* In relation to falls for Consumer C, the provider asserts Consumer C only sustained 9 falls and included additional documentation to show that. The provider also included information that shows after each fall staff reviewed the falls prevention strategies for effectiveness and implemented new strategies to try when required and ceased those, they identified were not effective.
* In relation to neurological observations for Consumer C, the provider has made an assertion that information contained in the Assessment Team report citing falls management policy and protocols is incorrect and the policy directs staff to undertake observations post fall half hourly for first 2 hours then hourly for an additional 2 hours and 4 hourly after that. An excerpt of the policy has been included as evidence of this. As such the provider asserts observations were done in accordance with falls risk management policy.

I acknowledge the information in the Assessment Team’s report; however, I have come to a different view and find the service was able to demonstrate they effectively manage high impact or high prevalence risks associated with the care of consumers. In coming to my finding, I have considered the information in the provider’s response that shows for Consumers F and L they are not ambulant and as such their beds in the lowest position does not constitute a mechanical restraint. I have also considered for Consumer C’s neurological observations post fall, the provider’s response includes documentation that shows monitoring was completed by staff in line with the service’s policy for falls risk management.

In relation to behaviour management (Consumers G, M and N), I have considered the additional information in the provider’s response that shows for each consumer mentioned in the Assessment Team’s report the service has a comprehensive behaviour management plan in place that includes triggers for behaviours and for each consumer interventions to guide staff practice. I acknowledge the information in the Assessment Team’s report and provider’s response in relation to incident management and have considered this in Standard 8 requirement (3)(d).

I acknowledge the actions taken by the provider to immediately rectify issues identified by the Assessment Team of mobility assessments not being up to date for Consumers F and L leading to the position of consumers’ beds in the lowest position being a potential restraint and the actions on the plan for continuous improvement included in the provider’s response of a review of care planning documentation. I encourage the provider to continue with their systematic reviews of consumer care information.

Based on the reasons above, I find requirement (3)(b) in Standard 3 Personal care and clinical care compliant.

In relation to requirements (3)(c), (3)(d), (3)(e), (3)(f), and (3)(g) consumers and representatives felt confident staff respond to any changes in consumer condition in a timely manner and contact the medical officer when needed. Consumers and representatives confirmed consumers do not have to repeat their needs and preferences for care to other providers and were satisfied staff communicated their needs appropriately. Documentation confirmed where deterioration in consumer condition is identified staff respond in a timely manner.

Consumers and representatives confirmed consumers have access to other providers of care when they request or need and staff action referrals to those providers of care appropriately, including medical officers and allied health professionals. Consumers and representatives were satisfied staff maintained high standards of infection control. Staff demonstrated knowledge of infection control principles and the organisation’s policy and procedures in place to minimise the spread of infection. Observations confirmed staff adhere to infection control precautions, including the appropriate use of personal protective equipment. Documentation confirmed where required antibiotics are prescribed for an appropriate amount of time.

Based on information above, I find requirements (3)(c), (3)(d), (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

Consumers and representatives confirmed supports for daily living are tailored to consumers’ needs and provided examples of how they are supported to maintain their independence, including through tailored allied health programs and specialised mobility equipment. Consumers described how they are supported to maintain important connections within and outside the service community, including the creation of a needlework group that meets weekly and can do the things of interest to them through engagement with the lifestyle program of which consumers confirmed they consulted in the development of that program.

Consumers and representatives were satisfied with the quality and quantity of meals and confirmed consumers have access to alternative choices where they wish to have something specific or that is not on the menu. Documentation sampled showed consumers’ likes and dislikes for meals are recorded, including any risks in relation to assessed dietary needs. Consumers confirmed they are supported by staff with their emotional, spiritual and psychological needs, including through individual sessions, volunteers visiting, poet therapy sessions and church services delivered. Consumers confirmed equipment is provided to them when they need it to maintain their independence, including mobility and engage in the lifestyle program and were satisfied it was right for them.

Staff confirmed information about consumers’ condition and lifestyle supports required is communicated with them to enable them to deliver the right care to consumers. Staff described the ways in which they support consumers to engage in the lifestyle program and demonstrated and understanding of consumers’ likes, dislikes and preferences for meals and activities. Documentation confirmed referrals to other providers of care, including volunteers is done in a timely manner when requested or required.

Based on the information above, I find all requirements for Standard 4 Services and supports for daily living 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team recommended requirement (3)(b) in this Standard as not met as the service was unable to demonstrate the service environment was safe or consumers were able to move throughout the service in a safe manner. The Assessment Team identified risks to consumer safety in relation to smoking areas, hot water services, switchboards, and moveable barriers.

**Requirement (3)(b)**

The Assessment Team’s report included the following information and evidence gathered through observations and interview relevant to my finding:

* Observations of the internal courtyard of the memory support unit identified it was used as a smoking area which was not a designated smoking area. Smoking equipment, including ash tray and smoking blanket were observed in the area. Management confirmed the area was used for smoking during a COVID-19 outbreak at the service.
* Yellow expandable barriers with extendable legs on them were observed across consumer room doors and hallways throughout the service. Staff confirmed the barriers were in place to prevent one consumer from entering other consumers’ rooms.
* The service had not completed a risk assessment for the yellow barriers to identify any risks associated when they are in place, including falls risk or consideration of strategies if there is an emergency and access is required.
* Consumers confirmed the barriers were put in place as they were not able to lock their doors to prevent other consumers entering their rooms.
* Switchboards were observed to be unlocked and accessible by all, including consumers in all areas they were located except the memory support unit. There was no consideration given to risks for consumers living in areas outside the memory support unit who have a cognitive impairment being able to access the switchboards.
* Four of 5 hot water earns located throughout the service, including the memory support unit were observed not to have a locking mechanism on to prevent access to boiling water.
* The barbeque in the memory support unit was observed with the gas bottle still connected and an internal courtyard with garden tools, including shearers was open and accessible to consumers without risk assessments completed.

The provider acknowledged the deficits identified in the Assessment Team’s report and included the following actions planned and taken following the Site Audit visit in their response:

* Audit of all wall mounted hot water urns undertaken and all with dysfunctional safety mechanisms decommissioned.
* Hot water urns added to the preventative maintenance schedule.
* Education with staff to ensure understanding of risks of scolding injuries and the use of gas bottles.
* Signage and instruction sheets implemented for BBQs at the service.
* Memorandum to all staff regarding designated smoking areas.
* Locking of electrical switchboards in place.
* Undertaking risk assessments for all consumers identified with moveable barriers.

I acknowledge the provider’s response and the actions taken both immediately and post the Site Audit visit, however, I find they were unable to demonstrate the service environment is safe. In coming to my finding, I have considered the information in the Assessment Team’s report in relation to risks and hazards identified to consumer safety in the service environment, including a smoking area that was not a designated smoking area used during an outbreak by a consumer in the memory support unit, gas bottles attached to a BBQ in the memory support unit courtyard and sharp garden tools all accessible by consumers. Furthermore, the observations of electrical switchboards being unlocked and accessible to consumers, and others throughout the service environment and 5 hot water urns not having safety mechanisms to lock. I have also considered the service has in place barriers on consumers’ doors that pose a risk of tripping and falls to consumers and are in place to prevent consumers entering other consumers’ rooms without having risks assessments completed and strategies to manage those risks identified and implemented.

In coming to my finding, I have placed weight on the elements of this requirement that requires a provider to ensure the service environment which can include undertaking monitoring of the service environment to identify any potential risks and hazards to consumer safety to enable them to fix those. I acknowledge the actions the provider has taken and those included in the plan for continuous improvement and find more time is needed to enable efficacy of those.

Based on the reasons above, I find requirement (3)(b) in Standard 5 Organisation’s service environment non-compliant.

In relation to requirements (3)(a) and (3)(c), consumers confirmed the service environment felt homely, they felt safe living there, and their visitors were welcomed. Consumers and representatives confirmed the service is clean and well maintained and consumers have choice over how they decorated their personal spaces. Consumers and representatives confirmed when there is something that needs to be fixed staff do this in a timely manner.

Observations showed the service environment was clean and well maintained and consumers’ rooms were decorated with personal items, including photographs, furniture and decorative coverings. The service environment was observed to have navigational signage to assist and consumers were moving freely around each area.

Staff demonstrated knowledge of the service’s maintenance processes and described the way in which they escalate issues requiring attention to the maintenance team for fixing. Documentation confirmed the routine and preventative maintenance systems in place.

Based on the information above, I find requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment 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 they feel supported to provide feedback about care and services, including making complaints. Consumers confirmed they are supported in a variety of ways to provide feedback and make complaints, including advising staff, management, using written forms or raising issues in the resident meetings. Consumers and representatives were satisfied their complaints are used to make improvements and confirmed they are actioned in a timely manner and staff apologise if something has gone wrong.

Observations showed information about how to make complaints and accessing advocacy and other language services to raise complaints is displayed throughout the service environment for consumers and representatives to access. Consumers and representatives confirmed they were aware of how to access advocacy services to assist them in providing feedback, including complaints.

Staff demonstrated understanding of the service’s feedback mechanisms and described ways in which they supported consumers and representative to provide feedback, including making complaints. Documentation confirmed feedback, including complaints and suggestions made by consumers and representatives is used to make improvements to care and services with recent initiatives of a food focus group and cultural group commencing.

Based on the information above, I find all requirements for Standard 6 Feedback and complaints 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements (3)(a) and (3)(d) were found non-compliant following a Site Audit undertaken from 28 September 2021 to 30 September 2021 where it was found consumers were not satisfied with staffing levels, impacting on their care and services and care staff did not receive adequate training to effectively attend to complex care for consumers.

The Assessment Team’s report included several actions the service has taken to address the deficits identified at the Site Audit, including, but not limited to:

* A review of the roster was undertaken with additional ours allocated for clinical staff for night shift and completing care plan reviews.
* Call bell data being reviewed in real time by management and times outside 10 minutes followed up with staff.
* Call bell response times added to the resident relative meeting agenda for discussion.
* A review of the induction and orientation program for new staff to ensure staff are buddied with experienced staff when rostered.

The Assessment Team recommended requirement (3)(c) in this Standard as not met as the service was unable to demonstrate how they ensure staff are competent and qualified to undertake their roles to ensure consumers receive safe and effective care and services, specifically in relation to knowledge of the provision of individual care for consumers and the management of falls, behaviour, diabetes and incidents. The Assessment Team provided the following information and evidence relevant to my finding.

* Staff were not competent in the monitoring of diabetic consumers’ blood glucose levels (BGLs) and did not take appropriate action in response to consumers who had BGLs outside reportable ranges.
* Staff did not record BGLs in line with diabetic management directives.
* Staff had completed an insulin administration competency within the past 12 months prior to the Site Audit visit.
* For one consumer staff were not following falls management policies and did not review prevention strategies or undertake neurological observations following unwitnessed falls.
* Staff did not show understanding of restrictive practices in relation to chemical or mechanical restraint.
* Routine competencies for medication and wound care were not routinely completed for staff delivering the care.

The provider acknowledged the findings in the Assessment Team’s report in relation to diabetes management and included in their response a list of actions to address those:

* Education provided to all staff undertaking BGL testing and administration of insulin to ensure appropriately responding to levels outside medical officer’s reportable ranges.
* Undertaking a training needs analysis to assist staff engagement in training and education.
* Review 2023/24 training plan.
* Implementation of a Human resources management system.

Overall, in relation to this requirement the provider disagreed with the findings in the Assessment Team’s report and asserts staff are knowledgeable of consumers’ needs, citing various areas in the Assessment Team’s report where consumers and representatives have confirmed that. In relation to falls and restrictive practices, the information provided in Standard 3 requirement (3)(b) of the provider’s response asserts staff followed falls management policy and procedures when undertaking neurological observations and for consumers sampled on low low beds the provider asserts and provided additional documentation to confirm changes in mobility and Consumers F and L the bed position did not constitute a restrictive practice.

I acknowledge the provider’s response; however, I find they have not demonstrated the workforce is competent and effectively perform their roles in relation to the monitoring of consumers with diabetes and medication management. In coming to my findings, I have placed weight on evidence presented in Standard 3 requirement (3)(a) that shows staff were not competently delivering care in a safe manner to consumers requiring sliding scale insulin to manage their diabetes. Two consumers were administered insulin incorrectly on more than one occasion without staff identify the medication errors or reporting the incident. Furthermore, the provider’s response whilst I acknowledge includes statements from other areas of the report that consumers are satisfied staff know them, it does not include evidence of staff competencies in this area. I acknowledge the actions taken by the service to address the deficits and find those improvement actions will need time to be fully embedded to improve the competency of the workforce in this area.

Based on the reasons above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

In relation to requirements (3)(a), (3)(b), (3)(d) and (3)(e) consumers and representatives confirmed they felt there were enough staff to deliver care and services in a way that meets consumers’ needs, goals and preferences and consumers felt confident staff knew what they were doing and were adequately trained and had the knowledge and skills to do their jobs. Consumers confirmed staff treated them with respect and delivered care and services in a kind and caring manner. Staff interactions with consumers were observed to be respectful, kind and caring.

Staff confirmed they have enough support during shifts to undertake their roles effectively and they have access to regular training. Documentation confirmed staff receive regular training and their performance is monitored in various ways via incident management, observations and feedback from staff and consumers.

Based on the information above, I find requirements (3)(a), (3)(b), (3)(d) and (3)(e) 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. | Non-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. | Compliant |

Findings

The Assessment Team recommended requirements (3)(d) and (3)(e) in this Standard as not met as the service was unable to demonstrate an effective risk management system in relation to the management of high impact or high prevalence risks and the management and prevention of incidents. The service could not demonstrate effective clinical governance in relation to minimising the use of restraint. In relation to requirement (3)(e), I have come to a different view to that of the Assessment Team and include my reasoning further below under that requirement.

**Requirement (3)(d)**

The Assessment Team’s report included the following information and evidence gathered through documentation and interview relevant to my finding:

* Daily catchups and monthly quality and safety meetings did not identify risks, deficits in care, concerns and trends and alert management in relation to falls and behaviour management gaps, including not reporting of behaviour incidents.
* Clinical audits did not include nutrition, skin integrity, infections, wounds or pressure.
* Consumer C’s falls were not effectively managed, and 9 falls occurred prior to an investigation being undertaken which occurred at the request of Consumer C’s representative.
* Behaviour support plans did not include personalised strategies to guide staff with behaviour management and did not complete incident reports consistently.

The provider disagreed with the findings in the Assessment Team’s report and provided in their response the following additional information and commentary:

* Assertion staff adhered to falls risk management policy and included documentation to show neurological observations were completed in line with policy for Consumer C, sampled in requirement (3)(b) of Standard 3.
* Behaviour support plans provided for three consumers (Consumers G, M and N) that include triggers and personalised interventions to guide staff managing those behaviours.

The provider acknowledges staff are not consistently reporting physical or verbal aggression from consumers when it is to staff but asserts, they are doing this when directed towards other consumers. The provider has included in their response an action to address this as part of their plan for continuous improvement of education for staff in incident reporting. Information the provider’s response has included in Standards 3 and 7 shows staff undertook post falls management in line with the organisation’s falls risk management policy through the provision of documentation showing an evaluation of strategies conducted post fall for Consumer C with additional strategies trialled and ones not effective ceased. I have also considered evidence in Standards 2, 3 and 7 that shows behaviour support plans include triggers and interventions to guide staff with behaviour management.

I acknowledge the provider’s response and the additional information and commentary included however, I find the service’s risk management system is not effective in relation to the management of risks to consumer care or identifying incidents where medication is not administered correctly in line with medical directives placing consumers with insulin dependent diabetes at risk of harm. In coming to my finding, I have considered evidence included in requirement (3)(a) of Standard 3 that includes a sample of two consumers (Consumers H and J) who were on multiple occasions identified as having BGLs outside reportable ranges and on more than one occasion received insulin above (and on one of those occasions below) what was directed by the medical officer placing their health at risk. The provider asserts they undertake daily huddles with staff to ascertain any risks of care along with other clinical and quality committee meetings to provide risk management oversight, however, none of these elements identified these errors had or were occurring until the Assessment Team identified them. I acknowledge the actions the provider has undertaken and is planning to address these deficiencies, including immediately standing down those responsible for the errors from administering parenteral medication until they have achieved their competency again, education to all staff involved along with specific training with an external Diabetes specialist, and a review of the organisation’s Diabetes management policy, however, I find these actions need more time to be fully embedded.

Based on the reasons above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)**

The Assessment Team’s report included the following information and evidence gathered through documentation and interview relevant to their recommendation:

* The service maintains a psychotropic register and updated register showed 10 consumers prescribed regular or as required chemical restraint medications, and additional 10 consumers with a chemical restraint medication prescribed and 3 consumers identified as having a chemical restraint for behaviour management or anxiety.
* The register showed inconsistencies in the application of legislation when defining appropriate diagnosis for antipsychotic medications. Consumer N is prescribed an antipsychotic medication for behavioural and psychological symptoms of dementia (BPSD) that is not considered a chemical restraint whilst another consumer is prescribed the same medication for the same reasons and is considered a chemical restraint.
* The clinical incident analysis report does not include actions documented in relation to minimising psychotropic usage and regarding chemical restraint records staff to evaluate chemical restraint 3 monthly.
* Behaviour support plans do not guide staff or include limited interventions in behaviour management.
* Three consumers were identified with a low low bed in use and were able to mobilise.
* Monitoring systems in place including daily huddles, high risk meetings, incident reviews, monthly data collection and monthly meetings were not effective in identifying, managing and minimising the use of restraint.

The provider disagreed with the findings in the Assessment Team’s report. The provider asserts chemical restraint is evaluated monthly at the Quality safety meeting in consultation with each treating medical officer, and with each consumer’s nominated representative every 3 months. The provider’s response included for Standard 3 a copy of three behaviour support plans that showed they include triggers of behaviour and personalised interventions to guide staff to manage those behaviours. The provider in their response reiterates the assertion made in Standard 3 requirement (3)(a) Consumers F and L are not subject to mechanical restraint with the use of a low low bed as neither consumer is able to mobilise, they acknowledge mobility assessments did not have updated information in their response to Standard 2 requirement (3)(e) and included actions to address those of updating the mobility information for each consumer immediately following the Site Audit.

The provider acknowledges the information in relation to Consumer N and the use of psychotropic medication to manage their behaviour and asserts this was a single error and in the plan for continuous improvement included actions to review medications with the medical officer.

I acknowledge the findings and information in the Assessment Team’s report, however, I have come to a different view and find the service demonstrated they have an effective clinical governance system. In coming to my finding, I have placed weight on the information included in the provider’s response for Consumers F and L that shows they are not able to ambulate which, therefore, does not make their use of low low bed a mechanical restraint. I acknowledge the mobility assessments were not reflective of this change and have considered the evidence in the provider’s response that shows this was updated immediately following the Site Audit. In relation to the Consumer N and the use of psychotropic medication to manage behaviours, I acknowledge the provider’s assertion of this error and the additional actions taken to review consumers’ medications with the medical officer and I am not persuaded a single instance shows a systemic error in the service clinical governance framework. I have considered information in the Assessment Team’s report that confirms a psychotropic register is maintained and the service has considered the use of medications as chemical restraint as they have 10 consumers with a chemical restraint in place. I have also considered in coming to my finding the Assessment Team’s report in Standards 3 and 6 which confirms other elements of clinical governance are in place and effective, including antimicrobial stewardship and open disclosure.

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

In relation to requirements (3)(a), (3)(b), and (3)(c),consumers and representatives confirmed they are engaged in the development and evaluation of care and services, including direct input into the lifestyle program. Consumers confirmed their feedback is invited through regular resident and relative meetings conducted at the service and consumer satisfaction surveys.

Documentation confirmed the service has processes in place to ensure the organisation’s governing body is accountable for the delivery of safe, inclusive, and quality care, including through various reporting and monitoring systems and monthly reports that include quality indicators and continuous improvement updates provided to Client experience officer who provides an update at the monthly Board meetings.

The organisation has up to date policies and procedures in place to guide staff practice in relation to, organisational and clinical governance. Systems and processes are in place to ensure changes to legislation, continuous improvement is consumer focused, and the workforce is monitored at an organisational level to ensure staff numbers, skills and training is right.

Based on the reasons above, 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 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)