Braemar House

Performance Report

10 Windsor Road   
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**Commission ID:** 7758

**Provider name:** The Commissioners of the Presbyterian Church in WA

**Site Audit date:** 20 July 2022 to 22 July 2022

**Date of Performance Report:** 5 September 2022

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others;
* the provider’s response to the Site Audit report received 23 August 2022; and
* a Performance Report dated 3 December 2022 for an Assessment Contact – Site undertaken on 25 October 2021.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

## The Quality Standard is assessed as Compliant as six of the six specific Requirements have been assessed as Compliant.

## The Assessment Team found overall, consumers sampled considered that they are treated with dignity and respect, can maintain their identify, make informed choices about the care and services they receive and live the life they choose.

## Care files sampled include individualised information about each consumer and reflected preferences of care and aspects of their lives which are of particular importance in relation to their identity, culture and diversity. Consumers’ cultural identity is considered and informs the delivery of care and services which are culturally safe. Staff were familiar with consumers’ personal circumstances and consumers described staff as kind, respectful and supportive of their identity, culture and diversity. Consumers also indicated staff deliver care and services in a way that is respectful of their ethnicity, culture and relationship status.

Consumers are supported to exercise choice, maintain relationships and independence and communicate their decisions. Staff described how they consult consumers about their preferences relating to aspects of their care and described how they support consumers to maintain relationships of choice. Consumers confirmed they are supported to make decisions about when they are assisted with personal care, what they would like during meal service, the activities they wished to participate in, and are encouraged to maintain their independence.

## Consumers confirmed they are able to make decisions about how they wish to live their lives. Where a consumer chooses to engage in an activity which includes an element of risk, consultation with consumers and/or representatives occurs, dignity of risk assessments are completed, outlining risks involved and management strategies are developed. For consumers who choose to undertake activities which include an element of risk, care and clinical staff described strategies implemented to mitigate risks identified.

## Consumers confirmed they are provided adequate information to enable them to exercise choice about their day-to-day activities and personal and clinical care. Consumers receive information through a number of avenues, including meeting forums, newsletters, menus, activity planners and noticeboards. Staff descried how information is provided to consumers and how they assist consumers to understand the information. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

The Assessment Team found most consumers sampled considered that they feel like partners in the ongoing assessment and planning of their care and services.

Care files sampled demonstrated a range of assessments are completed on entry and on an ongoing basis. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop individualised care plans which incorporate each consumer’s goals, needs and preferences. Additionally, a range of validated risk assessment tools are used to identify risks and inform care planning, including in relation to pressure injuries, falls depression and pain and strategies are developed to mitigate risks. All representatives sampled indicated they are in regular contact with staff and involved in discussions relating to care planning and identification of risks.

Care files identified and addressed consumers’ needs, goals and preferences relating to care and services and there are processes to identify consumers’ preferences relating to advance care planning and end of life planning. Consumers said staff are familiar with their preferences, which is demonstrated in their daily routine and the care received. The service works with a palliative care consultancy team who visit and provide care planning support and direct assistance for consumers approaching end of life.

Care files demonstrated staff work with the consumer and/or representative to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Medical officers and Allied health professionals was also noted.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers. Care plans include information relating to consumers’ health and well-being, nutrition and hydration, medication and pain management, mobility, skin care, personal hygiene and behaviour management. Care plans are discussed with consumers and/or representatives following entry, at regular care plan review meetings and when circumstances change. Representatives are satisfied they are kept informed of the outcome of assessments and with any associated changes to the way consumers’ care is delivered.

Most care plans had been updated in response to incidents and changes in consumers’ health and condition. Representatives indicated the service contacts them to discuss changes to consumers’ care required following identification of changes or deterioration.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant.

Requirements (3)(a) and (3)(b) were found Non-compliant following an Assessment Contact undertaken on 25 October 2021, where it was found the service did not demonstrate:

* safe and effective personal and clinical care, which was best practice, tailored to consumers’ needs and optimised their health and well-being, specifically in relation to care planning and management of wounds and pain; and
* effective management of high impact or high prevalence risks, specifically in relation to management of weight and wounds, and monitoring of changes to psychotropic medications.

The Assessment Team’s report provided evidence of actions taken to address these deficiencies, specifically relating to Requirement (3)(a). However, at the Site Audit, the Assessment Team recommended Requirements (3)(a) and (3)(b) not met, as they were not satisfied the service demonstrated:

* improvements have been embedded or that one consumer was receiving safe and effective personal and clinical care; and
* effective management of high impact and high prevalence risks, specifically relating to pressure injuries and unplanned weight loss.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(b). I have provided reasons for my finding in the specific Requirements below.

In relation to all other Requirements in this Standard, the service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Care files sampled included end of life plans outlining consumer preferences for end of life care. The service works closely with a palliative care consultancy team to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. A care file for a consumer who had recently passed demonstrated ongoing monitoring of the consumer’s condition occurred to ensure end of life care delivery was in line with the consumer’s wishes, with the focus on maintaining comfort. dignity and choice.

Where changes to consumers’ health are identified, care files demonstrated, assessments and monitoring processes are implemented and timely referrals to Medical officers and/or Allied health staff initiated. Care staff were clear about their roles and responsibilities relating to identifying and escalating signs of deterioration. Additionally, where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff.

The service has an effective infection prevention and control program that is in line with the national guidelines. Application of standards and precautions used to minimise the risk and prevent the transmission of infections to consumers was demonstrated and there are processes to regularly check with Medical officers about antibiotic usage. Clinical staff demonstrated an understanding of how the need for, or use of, antibiotics is minimised and observations showed staff practicing appropriate infection control processes. Consumers, representatives and staff were confident the service is well-prepared to manage a COVID-19 outbreak and expressed their satisfaction with how a recent outbreak was managed.

Based on the evidence documented above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team were not satisfied the service demonstrated improvements made in response to the non-compliance in this Requirement, identified following an Assessment Contact undertaken on 25 October 2021, have been embedded or that one consumer was receiving safe and effective personal and clinical care. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* The representative indicated the consumer had been wearing the same top for three to four days, had bruising and the consumer did not like some staff as they were rough with them.
* On the second day of the Site Audit, the consumer indicated their teeth had not been brushed. The consumer was wearing a singlet top, with bed covers down around their lower chest and indicated they were cold. Care staff pulled the bed clothes up, however, did not change them into warmer clothing.
* On day three, Consumer A was observed not to have eaten their lunch which was placed on the table in front of them. Clinical management advised care staff had attempted to assist the consumer with their meal, however, they had ‘refused’.
* Care plan documents state the consumer requires staff to assist with meals and oral care.

Consumer B

* Consumer B is prescribed two psychotropic medications. The representative stated they felt the medications needed to be reduced and they were having a detrimental impact on the consumer’s overall health. The representative stated as the consumer was no longer mobile and generally weaker, their risk of aggression was reduced.
* The Medical officer had reviewed the medications and noted a possible side effect of the medication, however, indicated to continue the existing regime. Management were asked if the Medical officer had been informed of the consumer’s recent significant weight loss and change in functional ability and how this might affect the impact of the current medication regime. It was unclear if this had been identified as a risk to the consumer’s well-being, with management indicating they would speak with the Medical officer.

Consumer C

* Consumer C is prescribed a regular antipsychotic medication, however, does not have a supporting diagnosis. Management indicated the Medical officer had stated to continue using the medication.

The provider’s response included a Continuous improvement plan and Clinical response plan directly addressing the issues highlighted the Assessment Team’s report, as well as supporting documentation. The plans included responses, planned, completed and ongoing, and actions and interventions. The provider’s response included, but was not limited to:

In relation to Consumer A

* Representative’s concerns were not raised with staff and internal audits of charting confirmed daily change of clothing occurs and no records of bruising. Review of charting also indicated daily oral care was provided.
* Care staff were preparing the consumer for hygiene and covers were pulled up for warmth and to maintain privacy.
* Initial attempts to encourage Consumer A’s intake include leaving meals in front of them to stimulate appetite.

In relation to Consumer B

* Psychotropic medications were reviewed by the Medical officer in August 2022 with no changes made. For further root cause analysis, a referral from the Medical officer has been requested for further review of medications.

In relation to Consumer C

* A principle diagnosis has been obtained from a specialist.

Requirement (3)(a) was found Non-compliant following an Assessment Contact undertaken on 25 October 2021, where it was found the service did not demonstrate safe and effective personal and clinical care, which was best practice, tailored to consumers’ needs and optimised their health and well-being, specifically in relation to care planning and management of wounds and pain. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, developed a wound management policy and procedure; provided education to staff relating to wound management and best practice in relation to wound products; and implemented processes for wound reviews to be completed daily and to ensure food and fluid charts are reviewed weekly.

Based on the Assessment Team’s report and the provider’s, I find at the time of the Site Audit, the service did not demonstrate safe and effective clinical care that is best practice, tailored to consumers’ needs and optimises their health and well-being, specifically in relation to personal care and use of psychotropic medications.

In relation to Consumer A, I find care has not been tailored to their needs or optimised their health and well-being. An activities of daily living chart was included in the provider’s response to support that the consumer had oral care and a change in clothes on the days highlighted in the Assessment Team’s report. I have considered that while charting may have been completed, this may not necessarily indicate the care has been provided. I would encourage the service to review monitoring processes to ensure personal care provided is safe and effective and provision of such care is in line with each consumer’s needs and preferences. In relation to meals, the provider asserts meals are left in front of the Consumer to stimulate appetite. However, I have considered evidence in the Assessment Team’s report in Requirement (3)(b) of this Standard which indicates the consumer has lost 10kg since December 2021, with a 5kg loss recorded between May and June 2022, which indicates strategies have not been effective to ensure adequate nutrition and hydration is maintained.

In relation to Consumer B, I find care has not been tailored to their changing needs or optimised their health and well-being. The Assessment Team’s report indicates medications were reviewed by the Medical officer and while tremors were noted as a possible side effect of the medication, no changes in the medication regime were made at this time. However, there is no evidence to indicate that a change in the consumer’s functional ability had been escalated to the Medical officer. The consumer’s representative indicated the consumer was generally weaker and their risk of aggression was reduced. As such, I find use of the medications has not been effectively reviewed, in line with the consumer’s changing needs, to ensure the medications were used as a last resort for the least time possible.

In relation to Consumer C, I have considered that while psychotropic medications had been prescribed on a regular basis, a diagnosis to support use of the medication was not evidenced. I acknowledge the provider’s response indicating a principle diagnosis has since been obtained.

For the reasons detailed above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

The Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically relating to pressure injuries and unplanned weight loss. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer D

* A wound chart was implemented in January 2022 following identification of an unstageable wound. By May 2022, the wound had almost healed.
* In June 2022, the wound had deteriorated and appeared infected. A Wound specialist review indicated an area of the wound was subject to prolonged pressure and recommended pressure area care, side to side.
* The consumer was observed lying on their back during the morning of the second day of the Site Audit, although the repositioning chart stated the consumer had been placed on their side. The consumer was again observed lying on their back on two other occasions in the afternoon while the repositioning chart indicated the consumer had been repositioned on their side.
* Current repositioning strategies had not been evaluated or identified as ineffective, resulting in continued breakdown of the wound.

Consumer B

* Consumer B experienced significant functional deterioration during May 2022. In June 2022, pressure injuries were identified, with one wound described as being black.
* There were inconsistencies in wound charts, including descriptions of the wound appearance. Dressing changes were not consistently occurring in line with the wound management plan, however, did not appear to impact the clinical management of the wound.
* The incident report completed on identification of the wound indicated pressure reliving equipment was not being utilised. Wounds were identified as a suspected deep tissue injury, indicating early identification did not occur.
* The consumer lost 12kg in a one month period, however, no cause or investigation into the weight loss has been identified. A Dietitian review occurred in July 2022 and interventions implemented. Management stated it is too early to have demonstrated measurable benefit.

Consumer E

* Consumer E has aknown high risk of skin injuries. A wound chart was implemented in May 2022 following identification of a blister described as black.
* The depth of the wound was not recorded nor wound treatments consistently undertaken in line with Wound specialist’s recommendations, however, this does not appear to have impacted wound healing.
* The Occupational therapist stated following advice from the Wound specialist, equipment to off load pressure has now been purchased to reduce the risk of reoccurrence.

Consumer F

* Consumer F acquired pressure injuries prior to entry and an unstageable wound following entry. Timely pressure relieving interventions were not implemented to maximise healing of the heels and prevent the development of the unstageable wound.
* Consumer F was observed with both heels resting on a pillow. The clinical team stated the Wound specialist had not specified the need to off load pressure of heels, so this was not considered to be necessary.
* The Occupational therapist stated following advice from the Wound specialist, equipment to off load pressure from heels has now been purchased.

Consumer A

* Consumer A regularly refuses meals and while a Dietitian referral has been initiated, actions to identify the root cause of the consumer not wanting to eat or effective strategies to promote well-being and adequate nutritional intake were not demonstrated. The consumer has lost 10kg since December 2021 with a 5kg loss recorded between May and June 2022.
* Food intake charts over the past month show the consumer has refused the majority of meals. There is no evidence of escalation or action to address meal refusal. Nutritional supplements are documented as administered but there is no evaluation of effectiveness.

The provider’s response included a Continuous improvement plan and Clinical response plan directly addressing the issues highlighted the Assessment Team’s report, as well as supporting documentation. The plans included responses, planned, completed and ongoing, and actions and interventions. The provider’s response included, but was not limited to:

In relation to Consumer D

* The consumer was reviewed by an outreach service during the Site Audit. The review was pre-organised as part of the wound management plan. Equipment to aid positioning was initiated following an Occupational therapist review undertaken subsequent to the Site Audit and the Skin integrity assessment updated to reflect the intervention.

In relation to Consumer B

* Weight post illness in July 2022 identified a 12kg weight loss and food and fluid charting during this time indicated normal intake. The consumer’s weight range was reviewed and updated following a Dietitian review in July 2022 and the consumer’s weight has remained stable with no further weight loss recorded.
* Weekly wound reviews are undertaken and recorded, however, were not requested by the Assessment Team. Specialist pressure relieving equipment has been provided, as well as dressings to alleviate pressure.

In relation to Consumer E

* Specialised pressure relieving equipment was provided in May 2022. An outreach review recommended the heel was floated on a pillow while in bed, as observed by the Assessment Team. The wound has subsequently healed.

In relation to Consumer F

* Following weekly review of the wound four days following identification and the consumer’s pre-existing medical conditions, referral to the outreach program was made for review and treatment advice. Equipment recommended was implemented six days post review.
* A Comprehensive wound assessment has been completed and outlines prevention strategies and an Allied health review undertaken. Risks associated with staying in bed discussed with Consumer F.

In relation to Consumer A

* Following an illness in May 2022 and subsequent weight loss in June 2022, referrals were made to the Medical officer, Dietitian and Speech pathologist in May and June 2022.
* The consumer is a habitual food refuser and refuses Speech pathologist’s recommendations. A milkshake has been implemented to build nutritional status and negate food refusal and the consumer’s diet is supplemented daily by representatives.

Requirement (3)(b) was found Non-compliant following an Assessment Contact undertaken on 25 October 2021, where it was found the service did not demonstrate effective management of high impact or high prevalence risks, specifically in relation to management of weight and wounds and monitoring of changes to psychotropic medications. The Assessment Team’s report did not include evidence of actions taken by the service to address deficiencies identified.

Based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate effective management of high impact or high prevalence risks, specifically in relation to skin integrity, wounds and nutrition, including weight management.

In relation to Consumer D, I have considered that appropriate management strategies and specialist’s recommendations have not been effectively implemented or reviewed to ensure the consumer’s risk of pressure injuries was minimised. The consumer was identified with an unstageable pressure injury in January 2022 and while the wound was described as almost healed in May 2022, the area deteriorated in June 2022, with the specialist indicating the area had been subjected to prolonged pressure. While charting indicated the consumer had been positioned on their side, the consumer was observed lying on their back on three occasions during the Site Audit. Subsequent to the Site Audit, pressure relieving equipment has been implemented.

In relation to Consumer B, I find appropriate management strategies to minimise the risk of pressure injuries were not initiated following a change in the consumer’s condition in May 2022. Suspected deep tissue injuries were identified in June 2022, with one described as black. I have also considered that wounds were not appropriately assessed or treatments consistently undertaken, in line with wound management plans. While there is no indication this impacted wound healing, wounds should be monitored in line with management plans to ensure wound progression is monitored, wound deterioration is identified in a timely manner and actions taken accordingly.

In relation to weight management for Consumer B, I have considered appropriate actions were taken when a significant weight loss was recoded following a period of illness. Food and fluid charting at the time did not indicate a change in the consumer’s intake. Referrals were initiated to appropriate Allied health professionals and as indicated in the provider’s response, weight has remained stable and no further weight loss recorded.

In relation to Consumer E, I find appropriate management strategies to minimise the consumer’s known risk of pressure injuries were not initiated. While the provider’s response indicates pressure reliving devices and equipment were implemented in May 2022, these interventions were initiated following identification of a blister described as black. I have also considered that wounds were not appropriately assessed or treatments consistently undertaken, in line with wound management plans, however, note that this did not appear to impact wound healing. The provider’s response indicates the wound has since healed.

In relation to Consumer F, I have considered timely and appropriate management strategies were not implemented to minimise the consumer’s risk of pressure injuries or support wound healing. The consumer entered the service with pressure injuries and subsequently developed a wound described as unstageable. I acknowledge the provider’s response indicating that following identification of a wound to the toe, appropriate measures were initiated, including referral to Allied health specialists and equipment. However, management strategies, specifically equipment to offload pressure, were not initiated until 12 days following identification. Additionally, the consumer was observed during the Site Audit with both heels resting on a pillow, with clinical staff indicating as the Wound specialist had not specified the need to off load pressure of the heels, they did not consider this necessary.

In relation to Consumer A, I have considered that strategies to ensure adequate nutritional intake have not been monitored and reviewed for effectiveness. I acknowledge the provider’s response indicating referrals to the Medical officer and Allied health specialists were initiated following a period of illness and weight loss in May/June 2022. However, food intake charts indicate continued refusal of meals and while nutritional supplements are documented as administered, there has been no review to evaluate the effectiveness. The provider’s response indicates additional strategies to improve the consumer’s nutritional intake have been implemented, subsequent to the Site Audit.

In relation to Consumers B, E and F, I have also considered that staff failed to identify changes in skin integrity, with wounds for these consumers described as suspected deep tissue injuries, black and unstageable. Consumers should expect their skin integrity to be monitored during activities of daily living and changes to skin integrity identified and escalated to ensure appropriate and timely review and actions are initiated.

For the reasons detailed above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

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

*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.*

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

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) in this Standard as not met. The Assessment Team were not satisfied the service demonstrated each consumer receives safe and effective supports for daily living which meet their needs, goals and preferences and optimises their independence, well-being and quality of life.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(a). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. Care files included information specific to each consumer and interventions to assist emotional, spiritual and psychological well-being, including their history, pastoral care and leisure and lifestyle needs. Consumers said staff know them and provide them with daily supports and services which meet their emotional, spiritual and psychological well-being

Services and supports for daily living are provided which enable each consumer to participate both in the internal and external community, maintain and develop social and personal relationships and participate in activities that are important to them and which they enjoy. The activity program is designed collaboratively with input from consumers, representatives and staff. Consumers’ interests, preferences and feedback are considered and incorporated into the activities program which includes a range of activities offering physical, emotional and sensory stimulation. One-to-one support is provided for consumers who prefer individual support, are isolated and/or who may have cognitive impairments impacting their ability to participate in group activities. Consumers described how the service assists them to do things they enjoy, maintain social and personal relationships and participate in activities.

Care files demonstrated information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely are referrals are initiated. Consumers and representatives said staff know consumers well, including their routines, how they like care provided, what they enjoy doing and who is important to them

Meals are prepared and cooked in line with a four-week rotating seasonal menu, developed with input from a Dietitian. Care files reflected consumers’ dietary needs and/or preferences, including specific cultural and spiritual requirements, likes and dislikes and there are processes to ensure this information is provided to staff, including catering staff. Consumers said they enjoy the food, there is plenty of choice and variety and they don’t go hungry.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Internal monitoring processes ensure equipment provided is maintained.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-compliant

*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.*

The Assessment Team were not satisfied the service demonstrated each consumer receives safe and effective supports for daily living which meet their needs, goals and preferences and optimises their independence, well-being and quality of life. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* The care plan indicates the consumer’s arm is to be supported with cushion whilst in bed and a splint is to be in place in the mornings and removed in the afternoon. A notice in the consumer’s room included this directive and a picture of the correct positioning of the cushion.
* On days one and two of the Site Audit, the consumer was observed with the cushion in an incorrect and unsupportive position, and the splint was not in place. In the afternoon of day and one, the splint was still in the same position on the consumer’s cupboard.
* Care staff said they didn’t need to do anything in particular regarding positioning or other supports for Consumer A but ensure they are comfortable. The said the consumer refuses to wear the splint and they report this to nursing staff.
* Clinical management were unaware the consumer was refusing the splint and the cushion was not correctly position to provide support.
* Handover documents confirm morning staff to are to put the splint on and it is removed by afternoon staff and refusal of the cushion and splint are to be documented. Progress notes for the previous two weeks did not include any refusals documented.

The provider’s response included a Continuous improvement plan and Clinical response plan directly addressing the issues highlighted the Assessment Team’s report, as well as supporting documentation. The plans included responses, planned, completed and ongoing, and actions and interventions. The provider’s response described Consumer A as being resistive to care and at times, staff will need to wait prior to repositioning the cushion. The consumer refuses to wear the splint and following review by the Occupational therapist in August 2022, alternative strategies to the splint have been implemented. An intensive monitoring chart has also been developed for a four-week period to improve safe and effective delivery of personal and clinical care.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, each consumer was not provided safe and effective services and supports for daily living to meet their needs and optimise health and well-being.

In coming to my finding, I have considered that for Consumer A, effective services and supports for daily living have not been consistently provided. As evidenced through observations, interviews and documentation, supports have not been provided in line with the consumer’s assessed needs. While care staff indicated Consumer A refuses a splint to be applied, this had not been documented in progress notes, as directed on the handover document. Additionally, clinical management were unaware the consumer was refusing application of the splint and incorrect positioning of the cushion. As such, I find that this has not ensured timely review of effectiveness of current supports or ensured that Consumer A’s sense of well-being and quality of life is improved or enhanced.

For the reasons detailed above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Non-compliant with Requirement (3)(a) in Standard 4 Services and supports for daily living.

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The Assessment Team observed the service environment to be welcoming, easy to understand and optimises each consumer’s sense of belonging, independence, interaction and function. The service is spread over two floors designed to support functioning of consumers, including those with cognitive impairment. Each floor has access to outdoor areas with suitable furniture available for consumer use and comfort. Open forums are held with consumers and representatives to gather feedback on how they feel about the service. Consumers and representatives felt the service environment was welcoming, consumers are able to personalise their bedrooms and they feel at home.

The service was observed to be safe, clean, well maintained and comfortable and the service environment supports free movement of consumers both indoors and outdoors. Consumers were observed moving freely between outdoor courtyard and indoor areas. There are processes to ensure regular cleaning of consumer rooms and common areas is undertaken. Consumers indicated they feel safe, the environment is clean, well maintained and comfortable and they are able to access the outdoor areas with assistance being provided by staff as needed.

Furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumers. Staff described how they ensure the service environment and equipment is safe, cleaned and maintained. Preventative and reactive maintenance processes are in place and staff described how they report and manage maintenance issues, as well as hazards. Consumers were satisfied the furniture and equipment they use is safe, clean and well maintained.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant as four of the four specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken.

Consumers and others are encouraged and supported to provide feedback and make complaints through a range of avenues, including meeting forums, care and service review processes, feedback forms and management’s open door policy. Staff described how they respond to complaints or feedback raised by consumers and/or representatives, including escalating to registered staff and management. Consumers and representatives were aware of feedback and complaints mechanisms, including completing feedback forms, email, raising issues at meeting forums or verbally discussing with staff or management.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and on an ongoing basis. Feedback forms and external complaints, language services and advocacy information was also observed on display and suggestion boxes were available. Consumers were aware of advocacy services available and indicated they had been provided with information on how to make complaints, including external avenues if they felt uncomfortable raising concerns with the service.

The service has a framework to guide appropriate action in response to complaints and an open disclosure process is used when things go wrong. Complaints and feedback are entered on a register which demonstrated complaints are actioned and closed off in a timely manner. Staff are aware of open disclosure processes, including apologising where things go wrong and management provided an example of where an open disclosure process had been applied. Consumers stated they generally have not had a need to make a complaint, however, had full confidence that staff and management would resolve issues for them. One representative said an issue raised was dealt with promptly and clinical staff kept them up-to-date during the process.

The service demonstrated how feedback and complaints are reviewed and used to identify and drive continuous improvement. The Continuous improvement plan included improvements initiated in response to feedback from consumers, representatives and staff. Consumers were satisfied their feedback is used to make improvements across the service.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with all Requirements in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

The Assessment Team found overall, consumers sampled considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. The service has recently undergone a restructure to improve clinical care, uses a structured approach for rosters and staff allocations, recruiting and retaining members of the workforce, managing different types of leave and the use of contracted staff. Staff are allocated according to consumer needs, considering the type of care required, and times of day where care needs are greatest. Where consumers’ needs increase, the service has the capacity to increase staffing levels. Care staff said while they are busy, they can meet the needs of consumers. Consumers and representatives were aware there were staff shortages at times, however, consumers feel safe and comfortable and there are generally enough staff available each day to care for them.

Staff interactions with consumers were observed to be kind, caring and respectful. Staff are required to sign a code of conduct agreement on commencement acknowledging the organisation’s values. Most consumers said most staff are gentle, calm and caring and know them well and what is important to them. Two representatives said at times staff were not consistently kind and caring and the standard of care varied depending on the staff on shift.

There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles. Staff are required to complete corporate face-to-face and online training and an orientation program. Ongoing mandatory competency assessments are completed by all staff, relevant to their roles and there are processes to ensure these components are completed. Consumers and representatives felt confident staff are skilled enough to meet consumers’ care needs

The service has an onboarding process which involves a corporate orientation program, including mandatory training, and sets the expectations of care delivery and behaviour under the Standards. Ongoing training relevant to each role is provided and there are systems to monitor staff performance to ensure staff competency and knowledge. Feedback and complaints, observation of staff practice, audits and incidents are used to identify staff knowledge or experience gaps, with further training provided as required. Consumers and representatives considered staff were qualified, well trained and equipped and were able to provide safe care and services.

The service has a staff performance framework which ensures staff performance, including poor performance, is regularly assessed, monitored and reviewed. Staff performance reviews occur regularly following commencement and annually thereafter. Staff performance is monitored on an ongoing basis through review of feedback and complaints, audits, incidents and observation of staff practice. Staff are supported to improve performance and where the need for improvement, training and monitoring is identified, there are formal processes to ensure this takes place. There are processes to manage underperformance and management provided an example of where this process had been applied.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with all Requirements in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

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

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

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(d) and (3)(e) in this Standard not met. The Assessment Team were not satisfied the service demonstrated:

* effective systems to manage high impact or high prevalent risks associated with the care of consumers or to analyse, review, monitor and continuously improve incident management and prevention; and
* effective, embedded clinical oversight of best practice care and minimising use of restraint.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(d) and (3)(e). I have provided reasons for my finding in the specific Requirements below.

In relation to all other Requirements in this Standard, consumers sampled considered that the organisation is well run and they can partner in improving the delivery of care and services. Consumers are engaged in the development, delivery and evaluation of care and services through meeting forums, feedback processes and care and service review processes. The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Board satisfies itself that the service is meeting the Quality Standards through regular reporting through various committees, including in relation to clinical governance, client experience and budget matters. The governing body can request further information from the organisation and service to ensure consumers receive care and services in line with the Quality Standards.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and the Board is aware and accountable for the delivery of services.

Based on the Assessment Team’s report, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Compliant with Requirements (3)(a), (3)(b) and (3)(c) in Standard 8 Organisational Governance.

**Requirement 8(3)(a) Compliant**

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

**Requirement 8(3)(b) Compliant**

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

**Requirement 8(3)(c) Compliant**

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

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

**Requirement 8(3)(d) Non-compliant**

*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.*

The organisation demonstrated effective risk management systems and practices in relation to identifying and responding to abuse and neglect and supporting consumers to live the best life they can. However, the Assessment Team were not satisfied the service demonstrated effective systems to manage high impact or high prevalent risks or to analyse, review, monitor and continuously improve incident management and prevention. The Assessment Team’s report provided the following evidence relevant to my finding:

* A benchmark report is used to collect clinical incident data. Evidence that all clinical incident information was collected and collated on an ongoing basis and in a form enabling the service to analyse, review, monitor and continuously improve incident management and prevention was not demonstrated.
* Benchmark reports for May and June 2022 were difficult to interpret and did not easily and clearly show key risks associated with the care of the consumers, or how risks are analysed and trended.
* Management indicated the parameters for the current clinical indicators they use and benchmark reports were not effective in assisting the service to monitor the quality of care delivered.
* In relation to analysing clinical risks and identifying trends, management advised they do not have a clinical indicator and analysis report or similar, however, analysis is undertaken at monthly Clinical governance meetings.
* Minutes for July 2022 show some evidence of discussion of clinical indicators and incidents, however, did not include comprehensive information relating to clinical indicators and there was limited information of potential causes of incidents and improvements identified, including in the key areas of risk identified by management.
* The clinical indicator sections remained blank for August, October and November 2021 with minimal information in September 2021. In December 2021, the clinical indicator section repeated information documented in September 2022 minutes and the clinical incident analysis section of the minutes was blank.
* Minutes did not include information for January to June 2022.

The provider’s response included a Continuous improvement plan and Clinical response plan directly addressing the issues highlighted the Assessment Team’s report, as well as supporting documentation. The plans included responses, planned, completed and ongoing, and actions and interventions. The provider’s response included, but was not limited to:

* The current benchmarking system will be discontinued and a new internal key performance indicator spreadsheet has been initiated to inform incident trend analysis. Data collected will be tabled and at Clinical governance meetings to identify high impact or high prevalence risks, continuous improvement opportunities, policy review, staff training, and where identified, further clinical reviews and escalations.
* Developed Incident trend analysis guidelines to track, record and analyse key performance indicator data addressing underlying foundations for better trend analysis.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate effective risk management systems and practices, specifically in relation to managing high impact or high prevalence risks and managing and preventing incidents.

I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks. Benchmark reports, used to collect clinical incident data, did not clearly demonstrate key risks associated with consumers’ care or include trending or analysis. Additionally, Clinical governance meeting minutes included limited information relating clinical indicators and incidents, including causative factors and improvements implemented. As such, I find the organisation’s processes have not enabled effective identification of trends relating to individual consumers or considered effectiveness of current management strategies or that risks to consumers are monitored to identify increased risk and ensure timely actions are taken in response.

In relation to managing and preventing incidents, I have considered the organisation’s incident management system has not been effectively used to ensure that all incidents are identified, monitored and analysed to assist to identify trends and opportunities for improvement, or risks to consumers’ health and well-being are being minimised and/or eliminated.

For the reasons detailed above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

**Requirement 8(3)(e) Non-compliant**

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

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

The service demonstrated appropriate clinical governance processes in relation to antimicrobial stewardship and open disclosure. However, the Assessment Team were not satisfied the service demonstrated effective, embedded clinical oversight of best practice care or effective clinical governance processes relating to minimising the use of restraint. The Assessment Team’s report provided the following evidence relevant to my finding:

* The organisation has a new Clinical governance framework and appropriate governance structures which are still being developed and embedded to ensure effective clinical oversight of best practice care.
* Documents to demonstrate compliance with the Quality Standards were incomplete, including the incident register, clinical governance meeting minutes, psychotropic register, restrictive practice register and wound report. Management stated benchmarking reports are not effective in assisting the service to monitor the quality of care delivered.
* A psychotropic register and restrictive practice register dated April 2022 were incomplete, including gaps relating to a diagnosis to support use of the medication, non-pharmacological strategies trialled, date of Medical officer review and whether informed consent had been provided. On day three of the Site Audit, more complete documents were provided, however, gaps were still evident.
* Management acknowledged previous registers for monitoring restrictive practice were not user friendly and they are in the process of updating the overall monitoring system.

The provider’s response included a Continuous improvement plan and Clinical response plan directly addressing the issues highlighted the Assessment Team’s report, as well as supporting documentation. The plans included responses, planned, completed and ongoing, and actions and interventions. The provider’s response included, but was not limited to:

* Implemented a new internal key performance indicator spreadsheet to inform incident trend analysis. Data collected will be tabled and at Clinical governance meetings to identify high impact or high prevalence risks, continuous improvement opportunities, policy review, staff training, and where identified, further clinical reviews and escalations.
* Implemented a Wound register and developed a Guideline for prevention and reporting of pressure injuries.
* Developed a weight matrix spreadsheet and reviewed weight monitoring guidelines.
* Reviewed and updated the Restrictive practices policy and Psychotropic medications guidelines, completed a Psychotropic medications register which will be reviewed monthly and updated the Restrictive practice register.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate an effective, embedded clinical governance framework or effective clinical governance processes relating to minimising use of restraint.

I have considered that while a clinical framework is in place, the framework is new and governance structures are still being developed and embedded. I have also considered that information, including incident registers, clinical governance meeting minutes, restrictive practice registers and wound reports were incomplete. As such, I find this has not enabled effective clinical oversight to occur or opportunities to improve reliability, safety and quality of clinical care and outcomes for consumers to be identified.

In relation to minimising use of restraint, I find the organisation’s monitoring processes were not effective. Both the psychotropic and restrictive practice register were incomplete. As such, I have considered that this has not ensured effective monitoring and oversight of consumers subject to restraint or enabled opportunities to minimise the use of restrictive practices to be identified.

For the reasons detailed above, I find The Commissioners of the Presbyterian, in relation to Braemar House, to be Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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 Requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that care provided is tailored to their needs and optimises their health and well-being; and
* provide appropriate care relating to management of skin integrity, wounds, restrictive practices and weight loss.
* Ensure policies, procedures and guidelines in relation to provision of personal and clinical care and management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to provision of personal and clinical care and management of high impact or high prevalence clinical risks.

**Standard 4 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to provide consumers with safe and effective services and supports in line with their assessed needs, goals and preferences.
* Review monitoring processes relating to services and supports for daily living to ensure consumers are provided care in line with their assessed needs and preferences.

**Standard 8 Requirements (3)(d) and (3)(e)**

* Review the organisation’s risk management processes in relation to managing high impact and high prevalence risks and managing and preventing incidents.
* Continue to embed and improve the organisation’s overall clinical governance framework and governance processes in relation to minimising use of restraint.