Performance

Report

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| Name of service: | Canberra Aged Care Facility |
| Service address: | 48 Archibald Street LYNEHAM ACT 2602 |
| Commission ID: | 2984 |
| Approved provider: | Bunyundah Nominees Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 20 September 2022 |
| Performance report date: | 27 October 2022 |

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 Canberra Aged Care Facility (**the service**) has been prepared by Gill Jones, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 12 October 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Other relevant matters:

A decision was made on 14 January 2022 that the service was non-compliant in Standard 3 Requirement (3)(a), Standard 7 Requirement (3)(e), and Standard 8 Requirement (3)(c) following a site audit undertaken 23-26 November 2021.

A Directions Notice was issued 28 January 2022.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |

Findings

A decision was made 14 January 2022 that the service was non-compliant in this requirement following a site audit undertaken 23-26 November 2021. During the site audit the Assessment Team found consent documentation for consumers where restrictive practices are being used are not consistently being signed, are not reviewed every 3 months (as management stated is their policy), and inacuracies in the indication of psychotropic medication were observed. Futhermore, a consumer under the care of the public guardian, did not have consent for psychotropic medication signed by the public guardian.

During the assessment contact on 20 September 2022 the Assessment Team found the service was unable to demonstrate best practice clinical care is being followed in relation to a small number of consumers prescribed medication deemed to be chemical restraint. For a small number of consumers there was an inconsistent approach to documenting the use of chemical restraint and incomplete consent documentation. The Assessment team identified six consumers being treated with psychotropic medication including Risperidone and Haloperidol to treat symptoms including agitation and restlessness. As none of these consumers were being treated with this medication for a diagnosis of a mental health condition, a physical illness or a physical condition the use of this medication met the definition of chemical restraint as the use of the medication was for the purpose of influencing a person’s behaviour. Under the Quality of Care Principles 2014, if chemical restraint is being used, then Approved Providers must have in place a behaviour support plan which includes information on assessment, monitoring, review and provision of consent.

For the six consumers identified, the GP had not identified that the medications in use met the definition for chemical restraint but the service were aware that these consumers were taking these medications The Assessment Team identified that the service understood their obligations with regard to the use of these medications as chemical restraint and were working with the GP to improve their understanding of the legislation and to correct the documentation. The Assessment team found one of the six consumers had a consent form that had not been signed by the consumer/their substitute decision maker or their GP for the use of chemical restraint. Another consumer’s consent form was not completed fully by showing her diagnosis or the reason for the use of two psychotropic medications.

The Assessment team identified two consumers where it was unclear if the continued use of psychotropic medications had been reviewed regularly. The Assessment Team also identified one consumer who had been admitted to the service on psychotropic medication and had been commenced on another soon after entry. Whilst some assessment documentation was available the service was unable to demonstrate that a comprehensive assessment was undertaken prior to the introduction of a second psychotropic medication. It was also unclear if the substitute decision maker was fully aware that another psychotropic medication had been commenced. Furthermore, this consumer’s behaviour support plan identified goals to manage her anxiety but did not identify the strategies/interventions to guide staff practice. Lastly, the Assessment team identified that, a consumer under the care of the public guardian, did not have consent signed by the public guardian for the use of psychotropic medication. This was the same consumer identified by the Assessment team during the site audit undertaken 23-26 November 2021.

The Approved Provider, in their response, stated that no consumers were taking unnecessary medication and all consumers were having a therapeutic effect from the psychotropic medications they were taking. The Approved Provider argued all consumers have the correct consent documentation in place as per the legislation. The Approved Provider explained that, as the GP did not identify the intent of the medication being to restrain the consumer, they had not correctly identified it as a form of chemical restraint. The Approved Provider indicated the GP made a mistake which is easily rectifiable.

In their response, the Approved Provider stated that three of the six consumers identified by the Assessment team not identified by the GP as being on medication classified as chemical restraint, were respite consumers. The Approved Provider stated the GP had charted the psychotropic medications the consumers had been taking at home on admission to the service so as not to upset their current medication regimes. The Approved Provider stated that, now that these consumers are permanent residents, the suitability of their medications will be reviewed. The Approved Provider stated that they have updated the consent forms and medication charts for the remaining three of the six consumers, identified by the Assessment Team. The Approved Provider stated that three consumers who were already permanent residents (not respite) had comprehensive behaviour plans that show how the service is managing their agitation and aggression which included non-pharma logical interventions for one consumer.

The Approved Provider stated that they have a good system for reviewing medications with GP’s reviewing medications every four months but did not provide any further information in relation to the two consumers the Assessment Team identified where it was unclear if the continued use of psychotropic medications had been reviewed regularly. The Approved Provider stated that they had approached the public guardian in September 2022 to sign the consent form for the use of psychotropic medication when the guardian signed a consent for environmental restraint for this consumer but the public guardian had declined. The email from the public guardian dated 12 September 2022 was shown to the Assessment Team when on site.

The Approved Provider did not respond to the Assessment Team’s findings that one consumer was commenced on a second psychotropic medication without evidence that alternative, non-pharmacological strategies were trailed/considered first. Neither did the Approved Provider respond to the Assessment Team’s concern about the consultation process with the substitute decision maker when another psychotropic medication was commenced, or that this consumers behaviour support plan did not identify strategies/interventions for managing her behaviour to guide staff practice.

I have considered the Approved Provider’s response. It is regrettable that the Approved Provider did not provide more evidence to respond to the Assessment Teams report. I am of the view that the Approved Provider understands their responsibilities in relation to restrictive practices and the Quality of Care Principles 2014. There are some documentation issues that need correcting with regard to the classification of chemical restraint and consent and the Approved Provider has shown they are committed to addressing these. I note these gaps have not had a detrimental impact on the health, safety or wellbeing of consumers as outlined both in the Assessment Team’s report and the response from the Approved Provider.

I find this requirement compliant.

# Standard 7

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| Human resources | |  |
| Requirement (3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

A decision was made 14 January 2022 that the service was non-compliant in this requirement following a site audit undertaken 23-26 November 2021. At the site audit the Assessment Team found the service’s staff performance framework was under development resulting in the service being able unable to demonstrate how it regularly assesses, monitors and reviews the performance of each member of its workforce.

During the assessment contact on 20 September 2022 the service demonstrated it has implemented systems since January 2022 to monitor, measure and review staff performance. Sampled staff where able to confirm they have received performance reviews, and documentation sighted confirmed performance reviews contain feedback from staff and management, and show completion and progress of reviews, and staff development plans.

I find this requirement compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

A decision was made 14 January 2022 that the service was non-compliant in this requirement following a site audit undertaken 23-26 November 2021. The Assessment Team found, in relation to restrictive practices, the service had not obtained consent for all consumers where restrictive practice is used.

At the Assessment Contact on 20 September 2022 the Assessment Team found the organisation has effective governance systems but was not able to demonstrate it effectively understands or manages reporting systems and staff practices in relation to regulatory compliance.

The Assessment Team reviewed the service’s management and understanding of restrictive practices. The Assessment team found that staff had received education on restrictive practices since the site audit and both staff and management, when interviewed, demonstrated they understood their responsibilities. The Assessment team found practices in relation environmental restraint were now in place but practices in relation to chemical restraint were still being fully implemented.

The Assessment Team identified one instance where a SIRS report was not made by the service following an altercation between two consumers. This incident had been correctly classified as a SIRS however it had not been reported. The service acknowledged the oversight and reported the incident during the assessment contact visit.

The Approved Provider, in their response, stated that the issues found by the Assessment Team in relation to the use of chemical restraint were minor clerical errors which were easily fixed. They indicated that they were working with a GP to educate them around the identification of chemical restraint as per the Quality of Care Principles 2014.

The Approved Provider, in their response, stated that the failure to report one SIRS incident was one, single, isolated event. The Approved Provider believed that they have effective governance systems. The Approved Provider provided evidence of other SIRS incidents that had been reported and explained that they had not sought to hide information and had dealt with this incident appropriately.

I have considered the Assessment Team’s report and the response by the Approved Provider and find that I am persuaded by the Approved Provider’s argument that they do have effective governance systems in place. I consider the Approved Provider does understand their responsibilities in regards to restrictive practices and SIRS reporting and their systems are effective.

I find this requirement compliant.

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