**Performance**

**Report**

**1800 951 822**

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| Name: | Cura In-Home Care |
| Commission ID: | 500053 |
| Address: | Level 4, 170 Burswood Road, BURSWOOD, Western Australia, 6100 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 September 2023 to 7 September 2023 |
| Performance report date: | 13 November 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.

# Service included in this assessment

Home Care Packages (**HCP**) included:

Provider: 272 Dutch Aged Care (Western Australia) Inc

Service: 19137 Cura In-Home Care

**This performance report**

This performance report for Cura In-Home Care (**the service**) has been prepared by A. Grant, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not Applicable** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Not Applicable** |
| **Standard 7** Human resources | **Not Applicable** |
| **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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | | HCP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | **Not Applicable** |
| Requirement 1(3)(b) | Care and services are culturally safe | **Not Applicable** |
| 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. | **Not Applicable** |
| 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. | **Not Applicable** |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | **Not Applicable** |

Findings

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, centred around some deficits in how the service records risks and how then risks are to be managed to support consumers. The previous Assessment Team found support coordinators were not consistently using information provided from the consumer and others to record the risk and how it would be managed on the support plan.

The Assessment Team noted in response to the non-compliance, the service support plans now include a risk/disaster rating section that covers clinical and non-clinical risks, what to watch out for and what actions are to be taken. The Assessment Team noted a dignity of risk form has been implemented to document and support consumers to live the best life they can. The service has adopted a suite of policies and processes including a dignity of risk procedure and process on documenting risk in the support plan. The service has provided training for support coordinators on risk management, in the home care environment.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated each consumer is supported to take risks to enable them to live the best life they can. Consumers and their representatives said they are encouraged to do things independently and staff respect the decisions they make. Where risk has been identified, the service evidenced it works with the consumer and their representative to discuss, agree, and consistently record outcomes of acceptance of the risk, actions or strategies to be put in place. The service has policies and processes they use to capture decisions made including dignity of risk. The service continues to review and develop documentation where dignity of risk is identified.

Support workers interviewed demonstrated awareness of dignity of risk through ensuring consumers had choice and adequate support to complete activities of daily living. Care documentation analysed by the Assessment Team showed that risk assessments are consistently completed for each consumer, discussed, recorded and there is ongoing consultation with the consumer and their representative. The Assessment Team noted the service has a dignity of risk policy, the policy describes dignity in risk and explains the way consultation, support, timely information and allowing risk appropriate to the circumstances can enable consumers to live the best life they can.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| 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. | **Not Applicable** |
| 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. | **Not Applicable** |
| 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

Requirement 2(3)(a)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed risk to consumers had not been identified through the assessment and planning process, to ensure support plans were sufficiently detailed to provide staff with information that guides the delivery of care while ensuring staff are aware of the risks associated with each consumer.

In response to the non-compliance, the service has implemented and improved the client assessment form to include validated assessment tools and a risk/disaster rating section. Each consumer’s assessment and planning, including consideration of risks are documented in the new support plan template. Feedback from support workers is used to inform supports included in the support plan. All support plans are quality reviewed by the manager before issuing. All coordinators have been trained on the use of validated assessment tools for assessment with quality documentation of what is expected in a support plan.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated there is assessment and planning, including consideration of risks to the consumer’s health and wellbeing to inform the delivery of safe and effective care services. Discussion with staff and review of documentation showed information is collected through discussion with the consumer, representatives and others involved in the consumer’s care. This information is used to identify where there may be risk for a consumer and what care and services are required to support their well-being.

Support workers interviewed by the Assessment Team described individual consumer’s routine, needs and preferences that are noted to be in line with the information provided in the support plan. Support workers demonstrated an awareness of consumers who are at higher risk of, for example, falls with alerts and information included on the electronic system available on the support worker’s mobile device. Documentation analysed by the Assessment Team showed individualised support plans are developed in consultation with the consumer and/or their representative around their identified goals, including assessments using validated assessment tools.

Requirement 2(3)(d)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed assessments were not fully completed and did not clearly identify risks to the consumers. As a result, support plans were not sufficiently detailed to provide staff with information to guide the delivery of care.

In response to the non-compliance, the service updated the client assessment form and is continually updating and improving this form. The Assessment Team noted all information is recorded in the electronic care management system and support workers have access through the mobile application. The Assessment Team noted copies of updated support plans are provided to consumers. The Assessment Team noted the support coordinators provide a handover to any support workers who are new to a consumer, at the consumer’s home.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated outcomes of assessment and planning are effectively communicated. Support workers stated they have access to the consumer’s support plan through the application on their mobile phones and can refer to the copy of the support plan held by the consumer. Staff said information is provided by phone, in person or email if there have been any changes made to the plan.

Requirement 2(3)(e)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed although the policy includes instances of when a support plan should be reviewed, support plans were not always reviewed when a consumer’s condition or situation changed, or when an incident occurred.

In response to the non-compliance, the service implemented a new support plan procedure. The Assessment Team noted all support plans have been reviewed and placed on the new plan template. The Assessment Team noted all support plans are reviewed by a manager or a peer before being issued in line with the procedure for quality control. The weekly care team meeting agenda was updated to focus on discussing clinical and risk factors for consumers, discussions include possible actions and additional reviews. The Assessment Team noted the discussions include highlighting incidents/accidents, medication errors and identifying which consumers are in hospital.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated support plans are reviewed regularly for effectiveness, following the service’s policies and procedures. Support plans are updated when circumstances change or when incidents impact on the needs, goals and preferences of the consumer.

Consumers when interviewed by the Assessment Team confirmed their support plan is reviewed and updated regularly. Two consumers indicated the assessment and reassessment processes are thorough, with updates made to the support plan when necessary. Consumers when interviewed by the Assessment Team indicated it is not just an annual review, coordinators regularly keep in contact with consumers and conduct a review if the consumer’s situation changes. Consumers confirmed they can make changes to their service preferences.

Support workers interviewed by the Assessment Team stated if they notice a decline in the consumer’s health, they will record a progress note in the system and contact the support coordinator to advise them of the change to the consumer. This leads to a reassessment/review of the consumer, which could also result in a referral to a clinical nurse or external services.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | **Compliant** |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | **Compliant** |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | **Not Applicable** |
| 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. | **Not Applicable** |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | **Not Applicable** |
| 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. | **Not Applicable** |

Findings

Requirement 3(3)(a)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed the service did not demonstrate each consumer gets safe and effective personal care, clinical care or both personal and clinical care, which is best practice, is tailored to their needs and optimises their health and well-being. The service lacked effective assessment and review processes, and the lack of comprehensive policies and procedures to guide staff practices.

In response to the non-compliance, the service implemented a suite of policies and processes as part of providing effective and safe clinical and personal care. Review of care documentation showed personal and clinical care assessments is now occurring including clinical risks assessment conducted by a registered nurse with strategies documented in the support plan to ensure care is provided safely. The service has a suite of policies and processes as part of providing effective and safe personal and clinical care.

During the Assessment Contact 6 to 7 September 2023, the service now demonstrates personal and clinical care is individually tailored for each consumer based on an assessment of the consumer’s individual needs, goals, and preferences. The support coordinators refer to nursing and allied heath staff seeking assessments and recommendations for the provision of best practice strategies as issues are identified.

Support workers interviewed were able to describe what personal and clinical care they provide to consumers. For example, support workers described how they support a consumer who is living with dementia. Support workers demonstrated their knowledge the consumers care needs and were able to describe how they provide medication assistance ensuring the consumer administers the right dose of his insulin and has sufficient supply of their medication. The Assessment Team noted this was consistent with the information provided in the consumers support plan.

A review of fifteen consumers’ support plans and assessments showed support plans are developed from using best practice validated assessment tools including but not limited to a falls risk assessment tool (FRAT) and a psychogeriatric assessment scale (PAS) are used with information gathered on admission from a range of sources including discharge summaries, aged care assessments and information from the consumer and nominated representatives.

Requirement 3(3)(b)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The identification of risks, and strategies to mitigate or reduce the risk to each consumer was not discussed with the consumer or their representative at the time of admission or during the ongoing review process.

In response to the non-compliance, the service ensured risk assessments were prioritised following the Quality Audit. Support plans were improved to capture clinical risks, what to watch out for, and what action is to be taken. A quality risk reporting structure has been implemented to record incidents, clinical concerns including a clinical nurse review for each event. The service has provided education to staff on the identification, reporting and recording of consumer risk and follow-up review of specific strategies.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated it effectively manages high impact and high prevalence risks associated with each consumer. Systems and processes are in place to assist staff to manage risk minimising the effect and the number of risks for consumers. The Assessment Team noted incidents are being reported with reviews completed and strategies implemented to further support the consumers.

Consumers interviewed stated the service effectively manages risks associated with the provision of care and services. For example, a consumer advised they experience fatigue when walking and is at risk of falls. The consumer stated they have been supported to get a physiotherapy review to improve their walking and pain management.

Support workers interviewed by the Assessment Team demonstrated knowledge of consumers who have high prevalence/high impact risks. For example, consumers with a diagnosis of diabetes have a specific diabetic management plan in place.

Documentation analysed by the Assessment Team showed that risks such as falls, diabetes, wounds, dementia, pressure injuries are all recorded in assessments, care notes and referrals. The Assessment Team observed referrals and ongoing communication to the clinical nurse consultant, various allied health professional services and general practitioners are involved in the consumer’s ongoing care.

Requirement 3(3)(d)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed the service did not effectively demonstrate deterioration or change of a consumer’s cognitive or physical function, capacity or condition is recognised and/or responded to in a timely manner. Referrals to health professionals were not consistently sought when issues were identified.

In response to the non-compliance, the service has reviewed processes and there is increased review and reassessment where deterioration is identified. This was observed through increased care documentation completed and risk tools being used as part of review of consumers, or where deterioration has been noted. The Assessment Team noted referrals to the clinical nurse and allied health professionals are consistently sought when there is a change in the condition of a consumer. Training has been provided to staff to understand their role and responsibility in reporting where they have observed or have been told about deterioration by the consumer or the representative. Staff confirmed they have completed education from a clinical nurse and understand their responsibility to report any changes.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated there are processes in place to identify where deterioration or change in a consumer’s cognitive function, capacity or condition has changed and a timely response is actioned. Staff interviewed understood their responsibility to report and act on any observed or discussed changes for the consumer for follow up by the support coordinator and registered nurse.

Consumers interviewed said that the service is supportive and responsive to any changes to their condition, and they are encouraged to discuss changes and feel comfortable contacting the service anytime. For example, a consumer stated they have regular contact from the support coordinator every week who encourages them to discuss any changes in their care needs following their previous multiple falls.

Support workers are clear about their roles and responsibilities including identifying, escalating, and reporting signs of deterioration. Support workers stated if they identified a change in the consumer’s condition, they would contact their support coordinator immediately, record their observations in the consumers care notes and wait for further advice.

The Assessment Team noted the service has a policy and procedure around the deterioration of a consumer’s mental health, cognitive or physical function ensuring it is recognised and responded to in a timely manner. The information is available to all staff and includes how to report an incident, responsibility to identify and respond to any deterioration of health in a timely manner and completion of documentation.

# Standard 8

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| Organisational governance | | HCP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | **Not Applicable** |
| 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. | **Not Applicable** |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | **Compliant** |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | **Compliant** |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | **Compliant** |

Findings

Requirement 8(3)(c)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed the service did not demonstrate there is effective information management in relation to assessment documentation which guides staff to identify possible consumer risk and record how the risk and impact is managed on the consumer support plan. Systems to capture information were not always being used effectively to provide comprehensive information.

In response to the non-compliance, the service implemented various improvements, including various policies and procedures to address the information management deficiencies. The support plan was consolidated into one concise document, the client assessment form was updated to include a validated assessment tool section and a risk/disaster rating section and a quality advisory committee has been established. This committee reviews quality risk reporting on a bi-monthly basis.

During the Assessment Contact conducted 6 to 7 September 2023, the service demonstrated there are governance systems in place relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The service has policies and processes in place to guide staff across the governance systems and staff have received relevant training to assist them to do this.

*Information management*

The service has a password protected centralised electronic care management system, and all consumer information is available through this system. Staff have access through mobile devices at the point of care/service. The Assessment Team noted consumer documentation is stored securely. Staff interviewed confirmed they have ready access to relevant documentation and information about consumers. Support staff stated they use the application on their mobile device, email and speak with coordinators and scheduling staff to ensure they have current information. The Assessment Team noted they also have access to a printed copy of the support plan at the point of care. The service maintains an information management framework with various policies and procedures which address information management, including and information management policy, information dissemination policy, information technology policy and, information management and privacy procedure.

*Continuous improvement*

The service uses a continuous improvement plan and strategic plan to guide its improvements. Continuous improvements are identified through various mechanisms including feedback, complaints, incidents, suggestions and changes in compliance requirements. Management confirmed data across various areas of the service help to identify areas for improvement. For example:

* It was identified the support coordinators were spending a lot of time processing invoices, taking them away from management and support for consumers. The service changed processes to relieve the coordinators of this task.
* The CEO stated continuous improvement is discussed with the management committee and the CEO provides regular reports to the management committee.
* The Assessment Team sighted the plan for continuous improvement which showed evidence of areas for improvement identified through various mechanisms. It details actions to be taken, who is responsible, target date, and outcomes.

*Financial governance*

The service has financial governance systems and processes in place to manage the finances and resources required to deliver safe and quality care and services. This includes providing consumers with a budget upon entry to the service, and monthly statements which consumers confirmed are clear and accurate. The Assessment Team noted there is a financial officer who provides financial reporting which is reviewed by the management committee. The Assessment Team noted there is annual financial reporting and external auditing in place, the CEO includes financial management in reports to the management committee which meets monthly. The service has regular reporting on consumers’ home care funding levels, where there are underspent funds available, the CEO demonstrated there is discussion about how funds can be used to support the consumer. Consumer and representative feedback confirmed there is discussion about how unspent funds will be used.

*Workforce governance*

Management and staff are provided with a job description and have a clear understanding of their roles and responsibilities. The service has processes for onboarding new staff, including training relevant to the Quality Standards. The service has relevant policies in place to manage the workforce, including a performance review policy. Training is provided to staff through an online training system as well as face to face training provided by service staff and external training providers.

*Regulatory compliance*

The CEO said the service is a member of a peak industry body and the CEO is on the divisional council of this body. The service receives alerts from various State and Australian Government departments to understand changes as they occur. Management attends various Commission webinars and other industry specific webinars to ensure the service is kept up to date on the aged care reforms. The service has an electronic incident management system, with staff provided with training on how to use the system. Management reviews incidents to identify systemic issues and improvements.

*Feedback and complaints*

The service has a feedback and complaints system which is monitored by the management team. There are various policies and procedures addressing how the service gathers and responds to feedback and complaints. Reporting is completed to inform all levels of the service on feedback and trends for complaints. The service uses feedback and complaints as a source for identifying opportunities for improvement.

Requirement 8(3)(d)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed the service did not demonstrate effective risk management systems and practices for managing high impact or high prevalence risks associated with the care of consumers. The service was not using its assessment processes effectively to identify and record where there may be risks for the consumer. The service was not effectively using the incident management system to report, review and identify opportunities for improvement.

In response to the non-compliance, the service implemented new or improved policies and procedures to address clinical care and services including high-impact and high-prevalence risks. The hazard and incident reporting procedure were updated to include Serious Incident Response Scheme (SIRS) incident identification and response. The service implemented a full quality risk reporting structure to record and report on complaints, incidents, medication errors, clinical concerns, and medication controls. The Assessment Team noted staff have been provided relevant training and a quality advisory committee commenced in June 2023, this committee reviews the quality risk reports bi-monthly.

During the Assessment Contacted conducted 6 to 7 September 2023, the service demonstrated it has effective risk management systems and practices to identify, assess and manage risks to the health, safety, and well-being of consumers. The Assessment Team noted incidents are recorded promptly in the service incident management system.

*Managing high-impact, high-prevalence risks*

The service demonstrated there is a process to identify risks associated with the care of consumers and strategies are put in place through consumer risk assessments. Analysis of documentation showed that risks to consumers is managed individually and outlined in each consumer’s support plan. The service has regular bi-monthly quality advisory committee meetings to review incident reports to identify trends and to discuss strategies for individual consumers as issues are identified, The Assessment Team noted a registered nurse is part of this process. The service also has a nurse consultant on the governing body who provides guidance.

*Identifying and responding to abuse and neglect of consumers*

Management advised staff are provided with training on elder abuse and SIRS. The Assessment Team sighted the training register which showed evidence of relevant training provided to staff. Staff demonstrated awareness of elder abuse and their role in reporting any suspected or actual issues relating to observation of physical abuse, emotional concerns and coercive behaviours of others.

*Supporting consumers to live the best life they can*

The service’s policies and procedures support consumers to live the best life they can by ensuring that any risks to the consumer are identified and strategies are developed and agreed upon to mitigate those risks. Management demonstrated knowledge and understanding of individual consumer risks and vulnerabilities.

*Incident management system*

The service has an incident management system in place. Staff interviewed explained how they report incidents whether observed or occurred prior to them attending to the consumer, or if deterioration of a consumer is observed. Staff confirmed they had received training on what to do when reporting an incident. A review of incidents showed there is timely reporting, investigation and actions are taken to prevent or reduce the likelihood of the incident reoccurring for each consumer. Incident reports are reviewed regularly to identify any trends and analysed by the quality advisory committee to consider what actions the service can take to minimise risks.

Requirement 8(3)(e)

The non-compliance with this requirement identified in the Quality Audit conducted 24 to 26 May 2022, showed the service did not have policies and processes to guide staff in understanding the service’s approach to open disclosure, antimicrobial stewardship and minimising the use of restraint. Staff had not been provided with education and were not able to describe how these topics are relevant to their roles.

In response to the non-compliance, the service developed and implemented various policies and procedures to address the deficiencies. This included antimicrobial stewardship added to the infection control policy and the creation of an open disclosure policy. The service also implemented a full quality risk reporting structure, with a quality advisory committee (including the support of a clinical nurse to review each event). A clinical nurse consultant has been appointed to the management committee to assist in improving clinical care and services provided to consumers.

During the Assessment Contacted conducted 6 to 7 September 2023, the service demonstrated it has a clinical framework in place, ensuring consumers receive safe, quality clinical care. The framework includes processes for open disclosure, management of restraint and antimicrobial stewardship. The clinical governance framework sets out the roles and responsibilities of the management committee and all staff and others who are involved in the care and services of consumers. Staff have been provided with relevant training about antimicrobial stewardship, open disclosure and minimising the use of restraint. The service collects and analyses relevant clinical care data for medication errors and other incidents. This information is discussed at various meetings, including the quality advisory committee. The CEO provides relevant reports to the management committee.

*Antimicrobial stewardship*

The Assessment Team noted the service has policies, procedures, and training in place relevant to antimicrobial stewardship. The Assessment Team noted the service has policy and procedures in place for infection control, including how an outbreak will be managed. Evidence analysed by the Assessment Team showed the service included information about antimicrobial stewardship in its December 2022 newsletter which was distributed to staff and consumers.

*Minimising the use of restraint*

The Assessment Team noted the service’s online learning platform includes courses which cover restraint, including a SIRS module. The Assessment Team noted the clinical care policy explains concepts relevant to minimising the use of restraint, including use of antipsychotic medication. The service included information about SIRS in its March 2023 newsletter.

*Open disclosure*

The service has an open disclosure policy and staff described what this means in practice. Staff described what they would do if something went wrong and their approach to resolving complaints. Management demonstrated how an open disclosure process is applied in the resolution of complaints and incidents. This information is discussed with staff during orientation and at regular training sessions.

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)