Doutta Galla Grantham Green Aged Care Facility

Performance Report

28-32 Magnolia Street   
ST ALBANS VIC 3021  
Phone number: 03 9364 5235

**Commission ID:** 3225

**Provider name:** Doutta Galla Aged Services Ltd

**Site Audit date:** 9 August 2022 to 12 August 2022

**Date of Performance Report:** 29 September 2022

# Performance report prepared by

J Liau, 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** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Non-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) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | 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 staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received on 9 September 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

* 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:

* The organisation:

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

## Assessment of Standard 1

Most consumers stated they are treated with respect and dignity by staff. Staff are aware of their individual and cultural preferences, and that they observe consumers’ right to privacy. Care planning documentation reflected what is important to consumers to maintain their identities. The service has documents and processes which outline consumers’ rights to respect and dignity.

Most consumers expressed satisfaction that they could exercise choice and make decisions about their care and services, while being supported to maintain relationships that are important to them.

Most consumers described how staff respect consumers’ culture, values and diversity and how this informs the daily provision of care and services. Review of care planning documentation reflected consumers’ cultural needs, interests and preferences. Staff provided examples of how they support consumers to achieve their goals.

Most consumers said they were supported by staff to take risks and live the best life they can, and staff described instances where a risk assessment was required and how consumers are supported to understand the risks and benefits of specific activities.

Most consumers/ representatives expressed satisfaction that the information they receive is current, accurate and is easy to understand. The Assessment Team observed meals menu, activities program, special events posters, and advocacy services information displayed on the notice board were current, accurate and easy to understand. Document reviewed show the service has a current privacy and confidentiality policy and all staff interviewed demonstrated a firm understanding of its principles and application.

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

## 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 NON-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 Assessment Team found the service did not ensure that they consider and discuss risk to the consumer’s health and well-being with the consumers/ representatives when planning consumers’ care. Review of documentation reflected practice gaps in this area. The approved provider responded to the site audit report and acknowledged the concerns raised by the assessment team.

The service did not demonstrate they have identified and addressed each consumer’s advance care planning or end of life planning. Review of consumer files showed some consumers did not have completed documentation as per the service’s policy and procedures regarding end-of-life planning.

The service did not demonstrate that ongoing assessment and planning was carried out with the consumers/ representatives, nor did the service support and encourage consumers to take part in assessing and planning their own care and services. Interviews with some of the consumers representatives showed the service did not discuss with them the consumers’ care plan, current medication regimen or lifestyle activities available at the service.

The service did not consistently demonstrate that outcomes of assessments are effectively communicated to the consumer representative or that the care and services plan is readily available to the consumers/ representatives.

The Assessment Team found the service did not demonstrate they regularly identify or assess each consumer’s goals and preferences in order to meet their needs safely and effectively. Interviews with consumers/representatives received mixed feedback. The approved provider responded to the site audit report and acknowledged the concerns raised by the assessment team.

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

## 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.*

The Assessment Team found the service did not demonstrate they consider and discuss risk with consumers/ representatives during assessment and planning to make sure care and services are safe and efficient. One of the sampled consumers is bed-bound and was having sponge baths since they entered the service in May 2022. The Assessment Team found the service did not have care planning documentation that showed alternatives to a sponge bath had been discussed or trialled for this consumer. The service did not assess the risks associated with not showering for an extended period with the consumer and their representatives.

The response submitted by the Approved Provider disputes the Assessment Team’s findings. The response submitted stated the consumer had five personal hygiene assessments completed since their admission and acknowledged in the response that a written dignity of risk form was not completed at that time, which has since been completed following the site audit. The Approved Provider also included in their response that they have now sourced a shower chair for the consumer.

Another consumer with multiple chronic conditions who entered the service some three months ago has no interim care plans in place to inform safe and effective care. Interviews with care staff described contradicting information regarding how they provide care to this consumer. Management responded to the Assessment Team by showing them an interim care plan dated on the day of the site audit.

The response submitted by the Approved Provider disputes the Assessment Team’s findings. The Approved Provider acknowledged that not all risks relevant to the consumer’s safety, health and well-being were identified and discussed at the time of admission, however they have since completed an extended care plan review following the site audit.

While the Assessment Team found the service had not demonstrated that assessment and planning, including the relevant risks to a consumer’s safety, health and well-being were always assessed and discussed with the consumers/ representatives in planning consumers’ care at the time of site audit, I have come to a different view. I find the Approved Provider’s response to be more compelling. Their response showed the service has since carried out a toolbox session with staff addressing assessment and care planning policy and completed a clinical review including updating of care plans for all the consumers.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has now demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

### Requirement 2(3)(b) Non-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.*

The service did not adequately demonstrate individualised care and service plans are documented for each consumer. Review of consumer files showed some consumers did not have end-of-life planning as per the service’s policy and procedures.

One consumer representative described the consumer as having three to six months left to live as informed by the medical officer. The representative stated the service did not discuss with them end of life wishes and preferences or the development of an advance care plan for the consumer. Review of documentation by the Assessment Team showed the consumer does not have an advance directive on file.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response stated that while the consumer had an advance care plan developed prior to admission, the service does not have a copy of the plan.

The Approved Provider acknowledged in their response that they have completed a review of all resident documentation following the site audit and noted several residents did not have an advance care directive. The Approved Provider stated they will review, update or develop an advance care plan for all consumers during their scheduled case conference session.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not demonstrate assessment and planning addressed each consumer’s advance care planning or end of life planning if the consumer wishes.

While I note the actions taken since the audit, the Approved Provider is still undertaking improvements as per the continuous improvement plan submitted. On balance, I am not satisfied the Approved provider has demonstrated compliance with this requirement. Accordingly, I find this service non-compliant with this requirement.

### Requirement 2(3)(c) Non-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.*

The Assessment Team found the service did not demonstrate they carry out ongoing assessment and planning with the consumer or their representatives and others who the consumer wants to involve in assessment and planning of their care and services.

One consumer’s representative said the service did not discuss with them the consumer’s care plan, current medication regimen or any lifestyle activities available at the service. Further, the consumer representative stated they have never been offered to view or sign the consumer’s care plan document.

The service also did not demonstrate they include other individuals or service providers in the consumer’s assessment and planning to ensure their continuity of care and services are focused and seamless. The same consumer was prescribed a psychotropic for behaviour management during their hospital stay, however interviews with clinical staff were not able to describe how they involve other individuals or providers in the consumer’s assessment and planning after they have returned to the service to review the ongoing need of the psychotropic use which may be associated with their hospital stay.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response submitted stated the service were unclear if the consumer’s representative was involved in the development of the care plan as there was no written information available at the service to show this had occurred. The Approved Provider submitted evidence of actions taken since the site audit that include

* review of the consumer’s care plan with the consumer representative involved in specific decision making
* a case conference with the consumer representative where Management apologised and offer a Welcome pack to the consumer representative.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not demonstrate that ongoing assessment and planning was carried out with the consumer or their representative, or support and encourage consumers to take part in assessing and planning their own care and services.

While I note the Approved Provider has since reviewed and renewed their compliance with the Resident of the Day schedule to ensure consumers/ representatives are advised of the upcoming case conference session, the Approved Provider is still undertaking improvements. I encourage them to embed these improvements into their usual practice to ensure assessment and planning is based on ongoing partnership with the consumer, including other organisations when appropriate. On balance, I am not satisfied the Approved provider has demonstrated compliance with this requirement. Accordingly, I find this service non-compliant with this requirement.

### Requirement 2(3)(d) Non-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.*

The service did not demonstrate that the outcomes of assessment and planning are communicated to consumer representatives or that the care and services plan is readily available to them.

For one consumer, the Assessment Team reviewed their depression assessment and psychotropic administration records on file. However, an interview with the consumer’s representative confirmed that the outcomes of the assessments had not been communicated or shared with them. Furthermore, the consumer’s representative said they were not aware of the psychotropic prescribed for this consumer and did not consent to the use of this medication to manage their behaviours.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response submitted stated the consumer’s medical history did not include depression at the time of admission as it was not included in the hospital discharge summary. However, the hospital discharge summary attached in the Approved Provider response was for another consumer not included in the site audit sample. I am unable to verify the information, given the information provided was for the incorrect consumer.

The Approved Provider did not submit any documentation showing the outcomes of the consumer’s assessment and planning were communicated to the consumer/ representatives prior to the site audit. Actions taken by the Approved Provider since the audit include

* a case conference was conducted where the consumer’s restraint care plan, medication administration care plan and end-of-life care plan were discussed with the representative.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not consistently demonstrate outcomes of assessment are effectively communicated to the consumers/ representatives or the care and services plan is readily available to the consumer/ representatives.

While I note the Approved Provider has since included in their continuous improvement plan to offer a copy of the care plan to consumers/representatives following care plan review, the Approved Provider is still undertaking improvements. I encourage them to embed these improvements into their usual practice to ensure the outcomes of assessments and planning are communicated to the consumer and documented in a care and service plan. On balance, I am not satisfied the Approved provider has demonstrated compliance with this requirement. Accordingly, I find this service non-compliant with this requirement.

### 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.*

The Assessment Team found the service did not always demonstrate they reassess a consumer’s needs, goals and preferences to make sure each consumer’s needs are met.

One of the consumer representatives stated it is the consumer’s preference to keep their hair and nails short, however the service did not review or reassess their personal hygiene requirement regularly to ensure their needs are met. Staff were not able to explain the process of regular reviews of this consumer’s care and services to ensure their personal preference and dignity was respected.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response submitted stated the podiatrist and hairdresser visit the service on a regular basis, however, did not explain why the consumer was not included on their list. Actions taken by the Approved Provider since the audit include:

* a personal hygiene assessment for the consumer which outlined their hair and nail care needs
* the consumer had a haircut on 25 August 2022
* the consumer had a podiatry service on 2 September 2022

Review of care plan documentation for another consumer show their wound dressing should be changed every two days, however the wound chart reflected the wound dressing was change every four days. Even though the reduced wound dressing regimen has shown no impact on the consumer’s current wound care management, the Assessment Team found the service was not able to demonstrate they regularly review the consumer’s care and services to reflect the consumer’s changing condition.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response submitted did not provide sufficient information in relation to the sampled consumer’s wound management prior to the site audit. The response stated the medical officer expressed no concerns to the consumer’s existing wound and the nurse has referred the consumer to a wound specialist following the site audit.

While the Assessment Team found the service had not consistently demonstrated that they identify or assess each consumer’s needs, goals and preferences regularly to meet their needs safely and effectively, I have come to a different view. I find the Approved Provider’s response to be more compelling. Their response showed the service had established procedures in place to ensure 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. After reviewing the information, I am satisfied these resources manage and support consumer care and services, as per this requirement of the Quality Standards.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

# 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 service did not demonstrate each consumer receives effective personal care or clinical care. Consumers subjected to restrictive practices are not always managed according to best practice as outlined in the service’s policies and procedures.

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with depression, hydration and reduced mobility. The approved provider responded to the site audit report and acknowledged the concerns raised by the assessment team.

The service demonstrated that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed.

The service did not demonstrate that change of a consumer’s mental health and the ongoing impact of severe pain is recognised and responded to in a timely manner. Review of progress note shows the severity and intensity of the consumer’s pain changes over the last few months and were not being recognised and responded in a timely manner.

The Assessment Team found the service did not consistently document and communicate consumers’ condition with others where responsibility is shared and did not demonstrate timely referrals to other individuals or health professionals when appropriate. The approved provider responded to the site audit report and acknowledged the concerns raised by the assessment team.

The service demonstrated systems and processes are in place to minimise infection-related risks. Staff interviewed confirmed they have received training in infection minimisation strategies and steps they could take to minimise the need for antimicrobials. The Assessment Team observed staff following appropriate infection prevention and control practices with no personal protective equipment (PPE) breaches.

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

### 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 service did not demonstrate they tailor and deliver personal and clinical care in line with the consumer’s needs, goals and preferences.

One of the consumers who experienced pain and changed behaviour were not being managed according to best practice and their clinical care was not tailored to their needs. The consumer was prescribed multiple pain relief medication including a “when required” opioid for breakthrough pain. Documentation reviewed by the Assessment Team show the service did not always monitor the effectiveness, side effects and adverse events of the medications after administration. The Assessment Team observed the consumer lying supine in bed with continuous tremors on three days during the site audit.

In relation to restrictive practice, the geriatrician recommends implementing a one-on-one specialised care for the consumer’s night-time behaviours, however there is no documentation that the non-pharmacological intervention to minimise the consumer’s agitation has been actioned.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The Approved Provider submitted progress notes with documentation gaps in relation to the consumer’s pain management. For example, the consumer’s pain interventions include receiving massage using a TENs machine or therapeutic massage, and at least 4 positional changes in 24 hours. The Approved Provider submitted in their response the Pain Chart for this consumer dated 2 Jun to 10 Aug that shows the service did not consistently manage the consumer’s pain according to the intervention strategies recommended.

The Approved provider did not submit any documentation in relation to how the service monitors the side effects or adverse events associated with the psychotropic used in this consumer, as per best practice.

For another consumer, the service did not demonstrate how the interventions or strategies developed to address the consumer’s physical and verbal behaviours are tailored to their specific triggering factors outlined in the consumer’s behaviour support plan and behaviours assessment. Further, the service did not demonstrate informed consent was obtained for the psychotropic used. The Assessment Team identified that a behaviour support plan had not been developed for this consumer, nor did the service demonstrate the use of alternative strategies to address the consumer’s changed behaviours prior to using chemical restraint.

The Approved provider disputes the Assessment Team’s findings. The Approved Provider stated the consumer’s care plan was created in June 2022 with a review date of 3 October 2022 and make no reference to the use of psychotropic or a behaviour support plan in their response.

For the third consumer, the Assessment Team found the consumer’s behaviour management was not being managed according to best practice and is not tailored to consumer’s needs. The Care Plan records the consumer can be verbally disruptive, paranoid, and blame other staff and residents for something they have not done and outlined that chemical restraint is to be used only when alternative strategies do not work. However, the service did not demonstrate how they have taken these triggering factors into consideration when developing the interventions and strategies to manage the consumer’s behaviours.

While I note the actions taken since the audit, the service did not demonstrate they do everything they can to provide safe and effective personal care and clinical care which is best practice, tailored to consumers’ needs and optimising the consumer’s health and well-being. Based on the available evidence, I am not satisfied the Approved provider has demonstrated compliance with this requirement. Accordingly, I find this service non-compliant with this requirement.

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

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

The Assessment Team found the service did not demonstrate they effectively manage high impact or high prevalence risks associated with the care of consumers.

One of the sampled consumers was prescribed “as required” psychotropic for agitation. However, a review of the behaviour chart for this consumer showed the last entry was completed on 7 December 2021. The progress notes noted the psychotropic had not been administered in 2022 and a pharmacy review in May 2021 had advised to cease this medication. Management explained they were reluctant to remove the psychotropic order from the consumer’s medication chart because the consumer may require something when they are anxious.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The Approved Provider stated the psychotropic prescribed is meant for the consumer’s anxiety related to their foot pain and is not for agitation. Further, the Approved Provider included in their response that the consumer’s psychotropic order was reviewed by a medical officer on four occasions and recommending no changes to the prescribed regimen. However, the medical officer recently reviewed the consumer on 2 September 2022 and has since removed the psychotropic order from their medication chart.

The same consumer was having sponge baths every second day since April 2022 due to the gangrene on their feet. The service did not demonstrate they effectively manage high impact or high prevalence risks associated with the consumer not having a shower for an extended period. The Approved Provider acknowledged the gap in delivering the consumer’s care. Actions taken by the Approved Provider since the site audit include

* a Resident of the Day assessment with associated risks of not showering for an extended period explained and discussed with the consumer/

representatives

* a skin integrity risk assessment
* a care plan review for the consumer

Another sampled consumer was also having sponge bath only since admitted to the service in May 2022. There is no documentation in care planning that alternatives to a sponge bath have been assessed, discussed or trialled. The service did not demonstrate they effectively manage the consumer’s high prevalence or high impact risks of acquiring pressure injury and other infections from not having a shower for an extended period and did not demonstrate they finds ways to reduce these risks. The Approved Provider acknowledged the gap in delivering the consumer’s care and have taken immediate action to address the issue.

In relation to dysphagia, this consumer has a standing order to monitor their food and fluid intake, however staff did not consistently follow the instruction. The Assessment Team found the Approved Provider did not demonstrate they effectively manage the consumer’s high impact risks associated with aspiration and dehydration. The Approved Provider submitted the fluid intake chart for this consumer with documentation gaps, such as the records for fluid intake from 8 July to 10 July, 12 July to 14 July, 24 July to 26 July and 2 Aug to 5 Aug were missing from the chart. The Approved Provider included in their response they have updated the consumer’s fluid chart and held a toolbox session with all staff reiterating the importance of recording fluid intake.

In relation to pain management, this consumer’s pain interventions include receiving massage and frequent positional changes. The Approved Provider submitted in their response the Pain Chart for this consumer dated 2 Jun to 10 Aug and clearly show the service did not consistently manage the consumer’s pain effectively according to the intervention strategies recommended. Actions taken by the Approved Provider since the site audit include

* a toolbox education to all staff ensuring they monitor and document the effectiveness for every PRN medication given
* on-going assessment of the consumer’s pain condition
* review and update the consumer’s pain assessment
* review and update the consumer’s comprehensive medical assessment

While the Assessment Team found the service had not demonstrated that high prevalence and high impact risk related to the personal care and clinical care for each consumer is being managed effectively at the time of site audit, I have come to a different view. I find the Approved Provider’s response to be more compelling. Their response showed the service has taken immediate action in response to the information raised in the assessment team report.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

### 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) Non-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.*

The service did not demonstrate they recognised or acted promptly when a consumer’s pain condition worsens. One of the sampled consumers with multiple chronic conditions were prescribed several pain relief medications for complex pain management. The service did not demonstrate they provider a higher level of ongoing care to meet the consumer’s changing pain needs. Review of progress notes showed the severity and intensity of the consumer’s pain changes over the last few months however staff did not consistently apply the specific pain interventions as per the consumer’s pain management plan. The Assessment Team observed the consumer lying supine in bed with continuous tremors during the site audit. The clinical staff interviewed stated the consumer is always in pain and is always asking for medication.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response submitted acknowledged the way they were recording the effectiveness of pain relief medication after administration was not consistent and have scheduled pain management effectiveness education following the site audit.

The Approved Provider included in their response the extensive record of the consumer’s progress notes, a PRN since first admission record and a PRN tracking individual resident report. However, there were gaps and deficiencies in the tracking record, for instance on the 20 August 2022, the consumer was given three doses of “when required” pain relief medication and “when required” muscle spasm medication but there is no record of staff evaluating effectiveness of either of the medications following administration. Moreover, the record shows the “prn” pain relief was given at 14:26 and “prn was effective” entered at 14:28, two minutes apart. There were no other observations following the consumer receiving the high-risk opioid medication to ensure it achieved the intended analgesic effect but not producing severe adverse effects associated with opioid medication.

The Approved Provider did not demonstrate staff regularly monitor the consumer following administration of psychotropic for adverse effects, to inform triggers for escalation when a consumer’s condition changes. The Approved Provider included in their response they have since conducted a review of the PRN medications records and scheduled toolbox education to all staff in relation to correctly documenting PRN administration effectiveness.

A review of progress notes dated June 2022 by the Assessment Team showed the same consumer has symptoms of depression that cause major interference with their daily activities. The service did not demonstrate they document routine observations in line with the diagnosis and there are no clear procedures to respond to triggers for care escalation when the consumer’s mental condition deteriorates. The Approved Provider did not submit a response in relation to this.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not demonstrate the systems and procedures in place to support staff recognise the deterioration or change in a consumer’s condition to meet the consumer’s needs.

While I note the actions taken since the audit, the Approved Provider is still undertaking improvements. On balance, I am not satisfied the Approved provider has demonstrated compliance with this requirement. Accordingly, I find this service non-compliant with this requirement.

### 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.*

The Assessment Team found the service did not demonstrate they transfer important information about a consumer’s care within and between organisations, including the consumer and their representatives, to improves outcomes for the consumer.

One of the sampled consumers was commenced on an antidepressant for major depression. The consumer representative interviewed indicated they were not aware of the consumer’s depression and their antidepressant prescribed. They confirmed the outcomes of the depression assessments viewed by the Assessment Team were not communicated or shared with them. Management stated the consumer has been quite happy and had not displayed any signs of depression.

The response submitted by the Approved Provider disputes the Assessment Team’s findings. The Approved Provider acknowledged that the outcomes of the recent findings may not have been formally discussed with their representatives and included in their response they were not able to confirm that it has occurred.

The same consumer was also prescribed a psychotropic for behaviour management, however the interview with the consumer representative confirmed the service did not communicate with them and did not obtain consent for the use of restrictive practice.

The response submitted by the Approved Provider disputes the Assessment Team’s findings. The response submitted show a case conference with the consumer representative has taken place following the site audit and use of psychotropics for behaviours management care was discussed at that time.

For another sampled consumer, the Assessment Team could not locate their interim care plan during the site audit. The Approved Provider submitted a copy of their care plan developed at their time of admission to the service.

While the Assessment Team found the service had not demonstrated they are actively communicating with others, including sharing information from assessments or findings to the relevant individuals or organisations, I have come to a different view. I find the Approved Provider’s response to be more compelling. Their response showed the service has taken immediate action in response to the information raised in the assessment team report.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

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

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

The Assessment Team found the service did not demonstrate timely referrals to mental health specialists and other allied health professionals such as occupational therapist and speech therapist.

One of the sampled consumers was reviewed by a speech pathologist who recommended a further swallowing assessment after a week or two, however the Assessment Team could not find any documentation to reflect this has been actioned. The response submitted by the Approved Provider disputes the Assessment Team’s findings and submitted in their response the relevant documentation that this referral was acted on in a timely manner.

Another consumer had a depression assessment performed on 21 July 2022 indicating they have major depression. They were reviewed by the medical officer on 7 August 2022 and subsequently commenced on an antidepressant. The Assessment Team found the service did not refer the consumer to the appropriate mental health support that meets the consumer’s needs in a timely manner. Interview with staff described the consumer had been quite happy and had not displayed signs of depression. The documentation review shows handover notes outlined to monitor the consumer’s behaviour and depression on every shift.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response included a behaviours assessment completed following the site audit explaining the consumer has now been referred to a geriatrician and is awaiting review. The assessment also included that the consumer will be referred to DBMAS, APATT, psychiatrist and Alzheimer’s clinician if required.

The third consumer with moderate risk of dysphagia was recommended for review by a speech pathologist or a dietitian sometime around mid-July 2022 following the initial assessment in June 2022. The Assessment Team found the service did not follow-up with the referral in a timely manner. The Approved Provider disputes the Assessment Team’s finding and evidenced that the speech pathologist has since completed the consultation following the site audit. The Approved Provider did not explain the reasons for delayed in processing the referral.

While the Assessment Team found the service had not consistently demonstrated the co-ordination of care with other providers or organisations in a timely manner to support the needs of consumers, I have come to a different view. I find the Approved Provider’s response to be more compelling. Their response showed the service had established processes to actively engage with external providers and others to ensure referrals are completed in a timely manner. After reviewing the information, I am satisfied there exists a systematic process in place to manage and support consumer care and services, as per this requirement of the Quality Standards.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

### 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 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

Majority of the consumers and their representatives stated consumers are supported by the service to maintain their emotional, spiritual, and psychological well-being. Review of consumers’ activity care plans reflect consumers interests and level of participation in activities offered at the service.

Most consumers are supported by the service to participate in community activities and staff work closely with external providers to ensure the wellbeing of consumers is maintained.

Review of care plans, progress notes and handover notes, evidenced the safe and effective sharing of consumer information between staff. Of those consumers sampled, their lifestyle care plan documentation is up-to-date and relevant to their current needs and preferences

Majority of consumers sampled said the meals are nutritious, well-portioned and flavoursome. Kitchen staff provided evidence of its “Resident Dietary Selection” document, which list consumers’ preferred food choice and portion size.

However, interview with one of the consumers described the service has not supported them to maintain their best possible level of independence and function for daily living. The approved provider responded to the site audit report and acknowledged the concerns raised by the assessment team.

The Assessment Team observed a variety of clean and well-maintained equipment and resources used to provide and support clinical and care services.

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) 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.*

Majority of the consumers and their representatives stated they are supported by staff to make independent decisions about activities they choose to participate at the service level and within their community.

One consumer with co-morbidities and is non-ambulant expressed dissatisfaction for not being able to access the outdoor areas due to lack of a suitable wheelchair and not able to operate their computer due to the lack of a suitable assistive technology equipment. Interview with the consumer said they had not been out of bed for two or three months as there is no suitable equipment to facilitate their movement and described they could not use their computer for daily living that meet their goals and preferences as the service do not provide assistive technology to facilitate this.

The response submitted by the Approved Provider disputes the Assessment Team’s findings. The response submitted outlined the service has been regularly liaising with the external providers to facilitate the consumer to be as independent as possible and maintain a sense of well-being. The Approved Provider stated in their response the challenges and barriers beyond their control when working with external providers. Actions taken by the Approved Provider since the audit include

* + a Zoom meeting with various external providers to discuss and review the consumer’s NDIS funding
  + an urgent referral to an occupational therapist through NDIS
  + a referral to the service’s occupational therapist to support the consumer’s preference of lifestyle and assistive technology
  + an in-depth review of the consumer’s assessment forms used to create the resident’s Lifestyle Profile in care planning
  + offered the consumer option of relocating their bed near the window to enable them to access outside view
  + to relocate the consumer to an assessed chair that is approved by the external provider to assist with pain management
  + reviewed and trialled a new Lifestyle form used to document residents’ lifestyle assessment
  + a Leisure and Lifestyle Meeting to discuss and ensure there is a consistent approach within the service to documenting consumer’s needs, goals and preferences and steps of incorporating such document in the three-monthly care plan review.

The Assessment Team found the service had not demonstrated they review each consumer’s preferences and ensure each consumer’s wishes are considered in providing the services and supports for their daily living. However, I have come to a different view. I find the service has since supported this consumer to safely maintain their best possible level of independence and function. Further, evidence supplied by the Approved Provider showed they support problem solving, including where risks arise, for example when there was difficulty engaging with external providers, so that consumers are still able to optimise their independence, health, well-being and quality of life.

With the above evidence and consideration in mind, I am satisfied the Approved Provider has demonstrated compliance with this requirement. Accordingly, I find the service compliant with this requirement.

### 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

Most consumers said the service environment is welcoming and homely. Further, consumers and their representatives said the service is safe, clean and well maintained.

Although most consumers/ representatives expressed their satisfaction with the equipment in use at the service, the Assessment Team found staff were not supported or educated by the service on how to operate the required equipment to deliver quality service. There was conflicting information provided by the Assessment Team, the Management Team, and the Approved Provider’s response in recording consumers’ weight using a weight scale and chair scale.

Management described the service is renovating a café connecting the inner area to the enclosed garden for consumers and visitors use.

Maintenance documentation reviewed by the Assessment Team indicated that cyclical maintenance and cleaning schedules are in place, as well as the fulfillment of reactive maintenance and cleaning requirements. Review of the Resident and Relatives Meeting minutes documented that resident said the service is clean and spacious.

The Assessment Team observed the service has wide corridors for easy wheelchair access, large communal areas and level access to the service’s secured outdoor areas.

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

## 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.*

Most consumers and their representatives expressed their satisfaction with the equipment at the service, however the system and procedures in place may not have supported or educated staff to use the equipment.

The Assessment Team found the service did not maintain their weighing scale to deliver quality clinical care. Review of weight charts submitted by the Approved Provider shows one of the sampled consumers had a weight loss of 6.17 kg over two weeks using a chair scale. At interview, Management stated the weight difference was due to the weighing machine not functioning properly.

The Approved Provider further clarified in their response the reduction in the consumer’s weight was due to the consumer being weighed without a sling and leg braces in the later instance. The Approved Provider acknowledged the battery for the weight chair was not working properly earlier, however the new battery was installed in July 2022. The Approved Provider also provided a copy of the job completion log for the above. The Approved Provider further stated that staff on duty during the site audit who commented the scale was not functioning may not have used it or known that the weighing machine has been checked by maintenance and assumed the weight machine was still faulty.

Another sampled consumer is required to be weighed monthly while they are on a high protein diet as per the care planning instruction. The Approved Provider submitted their weight record for June 2022 and July 2022, and stated the consumer refused to be weighed further.

While the Assessment Team found the service had not demonstrated that equipment in place is well-maintained, I have come to a different view. While I acknowledge there was some deficits in staff knowledge in operating the weighing machine, I have reviewed all the information provided and am persuaded by the Approved Provider’s immediate action of purchasing a new portable ceiling scale following the site audit. I am satisfied the Approved Provider is able to demonstrate equipment is safe and well-maintained. Accordingly, I find the service compliant with this requirement.

# 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

All consumers/ representatives expressed satisfaction they were encouraged and supported to provide feedback and make complaints. The process for submitting feedback to the service is discussed with all consumers /representatives during admission and during consumer and representative meetings. Staff described how they support consumers to provide feedback and make complaints.

All consumers/ representatives satisfied they had been made aware of and understood how to access advocates or language services if they wished to raise a concern. Staff explained the various means available to assist consumers with cognitive impairment or language barriers to submit feedback and were able to provide information about advocacy services.

All consumers / representatives were satisfied that actions had been taken to resolve their respective issues. They described how staff apologise when something goes wrong.

Management explained consumers feedback was valuable and encouraged. Further, Management described how complaints data are analysed, and actions are taken to improve the quality of care and services.

Complaints documentation reviewed identified appropriate action taken by Management. The Assessment Team observed advocacy and feedback information displayed throughout the service and observed language cards were implemented at the service.

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

## 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

All consumers/ representatives were satisfied with the number and mix of staff at the service. One of the consumer’s representatives said staff are very kind during the three years that the consumer has resided at the service, and staff knew the consumer very well. Consumers and representatives were satisfied staff were trained and supported to deliver the outcomes required by the Quality Standards.

Most staff described the process around staffing shortages and use of agency staff to maintain the provision of safe and quality care. Staff consistently explained that the service supports a strong commitment to teamwork which ensured no impact to the level of care provided to consumers where staff absences occurred. Staff said they were supported in their roles through mandatory training, regular performance reviews with their supervisors and a structured orientation program.

Management described the organisation’s recruitment and selection process, position descriptions, and qualifications to ensure staff are competent and capable of the position for which they are recruited. Management explained staff are required to undertake a skills assessment in core competencies upon commencement of employment and annually thereafter. Management further described how they identify knowledge or training gaps during incident report investigations, trending complaints and internal audit analysis to identify where additional training may be required.

Review of staff rosters demonstrated all shifts were covered, and call bell audits illustrated a timely response to calls. The Assessment Team observed positive and respectful interactions between staff and consumers.

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

## 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

All consumers/ representatives interviewed are satisfied with the way the service is managed. They expressed feeling safe at the service and living in an inclusive environment with the provision of quality care and services.

However, the service did not adequately manage high impact or high prevalence risks associated with the care of consumers and did not consistently follow the service’s policy and procedures in minimising the use of restraints.

Management described the service conducts regular audit in various areas of care and service delivery to identify and analyse trends. The audit results are then discussed at a service level and at the organisation level. In addition, the service includes these data in their continuous improvement plan for follow-up action.

The Assessment Team reviewed numerous policies and procedures relating to open disclosure, SIRS, privacy and clinical governance policy. All documentation reflected the relevant legislative requirements.

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

## Assessment of Standard 8 Requirements

### 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 service demonstrated systems and practices are in place to effectively identify and respond to abuse and neglect of consumers, to support consumers to live the best life they can and to manage and prevent incidents. Staff described the process of reporting SIRS incidents to the MyAgedCare portal and discussed SIRS decision support tools and flow charts. Staff explained how they would seek support from their supervisor if they were unsure of the reporting requirements. Staff stated identifying and responding to elder abuse learning module is included in their mandatory training.

Review of documents show Dignity of Risk authorisation forms are completed by consumers/ representatives. Staff described how they encourage and support consumers to live the best life they can.

However, the service did not demonstrate effective risk management systems and practices to monitor high impact risks associated with depression, pain, personal care, hydration, and reduced mobility were identified and mitigated in a timely manner.

For one of the consumers, their pain management, behaviour management, fall management and dysphagia management were not being managed according to the service’s policy and procedure. Progress notes reviewed by the Assessment Team evidenced documentation and clinical gaps in managing the consumer’s high impact or high prevalence risks. The service did not demonstrate how the risk management systems in place minimise and manage the high impact or high prevalence risks associated with the care of the consumer and did not adequately demonstrate they find ways to reduce or remove the risks in a timeframe that matches the level of risks it has on the consumer as discussed in Requirements 3(3)(a) and 3(3)(b).

The response submitted by the Approved provider disputes the Assessment Team’s findings. The Approved Provider submitted in their response a comprehensive plan for continuous improvement which address high impact and high prevalence risks associated with the care of consumers.

For another consumer who required hydration monitoring, the Approved Provider submitted their response outlining the service’s policy and work procedures in managing nutrition/ hydration and acknowledged there are opportunities to improve in this area.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not demonstrate they consistently monitor high impact or high prevalence risks associated with the care of consumers and take appropriate action in a timely manner if a risk has increased. While I note the actions taken since the audit, the Approved Provider is still undertaking improvements as per the continuous improvement plan submitted. Accordingly, I find the service non-compliant with this requirement.

### 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 understands and supports safety and quality in the clinical services it provides such as the antimicrobial stewardship and open disclosure. However, the service did not demonstrate how they effectively monitor consumers who are subject to restrictive practices. Although the service has established policies for minimising the use of restraint, management and clinical staff were unable to demonstrate this was applied consistently.

The service’s policy relating to minimising the use of restrictive practices outlines that a risk assessment is required to be completed where a form of restraint is deemed necessary, authorisation for the use of a restrictive practice is to be signed by the consumer's medical officer and representative and the requirement for restrictive practices is to be reviewed every three months.

The Assessment Team identified the service did not consistently follow this policy. In particular, the service was unable to demonstrate that comprehensive assessments were undertaken, and restrictive practice authorisation forms were signed where consumers were subjected to chemical restraints.

One of the sampled consumers was prescribed psychotropic for behaviour management, however they did not have a restrictive practice comprehensive assessment, or a behavioural support plan completed as per the service policy and procedure.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The Approved Provider agree a restrictive practice comprehensive assessment was not completed for this consumer as per the service’s policy. Actions taken by the Approved Provider since the audit include

* a comprehensive restrictive practices assessment for the named consumer
* an updated behaviour support plan for the named consumer
* a signed restrictive practice authorisation form for the named consumer

Another sampled consumer was also prescribed a psychotropic for behaviour management and has no behavioural support plan to guide their behaviour management as per the service policy.

The response submitted by the Approved provider disputes the Assessment Team’s findings. The response outlined the service’s work instruction, which stated that the behaviour assessment should commence after day seven of admission, to inform the development of a behaviour support plan. The response explained the consumer was admitted on 7 June 2022, followed by a behaviour assessment completed on 31 August 2022 (which is more than seven days since their admission) and subsequently the behaviour support plan was developed on 28 June 2022 and updated in September 2022. This practice is contradicting to the service’s work instruction.

I have reviewed all the information provided. I have placed weight on the Assessment Team’s evidence that the service did not demonstrate their staff has a systemic approach in minimising the use of restraint in accordance with legislation and the service’s policy and procedure. While I note the actions taken since the audit, the Approved Provider is still undertaking improvements Accordingly, I find the service non-compliant with this requirement.

# 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.

**In relation to Standard 2, Requirements 2(3)(b), 2(3)(c) and 2(3)(d)**

* Ensure that advance care directive documentation is included for each consumer and is accurate, up to date, shared and stored.
* Ensure that ongoing assessment and planning was carried out with consumer and/or representatives and other who the consumer wants to involve.
* Ensure that changes to care and services plan are communicated promptly to the consumer or their representative.
* Ensure staff have knowledge of and competence to meet the above.

**In relation to Standard 3, Requirements 3(3)(a) and 3(3)(d)**

* Implement processes to ensure care is tailored to each consumer’s needs and is consistently delivered with best practice principles applied, particularly for pain and restrictive practices.
* Establish systems and processes in communicating and responding to changes in health or functions of consumers; communicate appropriately and involve consumers, their representatives and others including carers and families.
* Ensure staff have knowledge of and competence to meet the above.

**In relation to Standard 8, Requirements 8(3)(d), 8(3)(e)**

* Establish systems and processes for managing high impact and high prevalence risks and review these systems to improve consumer care outcomes.
* Establish systems and processes to manage how restrains are used and review these systems to ensure it is accordance with legislation and the organisation’s policies on reporting the use of restraints.