Performance

Report

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| Name of service: | Esperance Aged Care Facility |
| Service address: | 17 Eyre Street ESPERANCE WA 6450 |
| Commission ID: | 7248 |
| Approved provider: | Esperance Aged Care Facility Inc |
| Activity type: | Site Audit |
| Activity date: | 15 November 2022 to 17 November 2022 |
| Performance report date: | 19 January 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Esperance Aged Care Facility (**the service**) has been prepared by A Kasyan, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the Site Audit report received on 12 December 2022; and
* the Performance Report dated 7 June 2022 in relation to the Assessment Contact conducted from 16 March to 17 March 2022.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 2 Ongoing assessment and planning with consumers:**

Requirement (3)(a): Ensure assessments, charts and monitoring records are completed to identify risks in relation to consumers’ care and to inform strategies to manage risks.

Requirement (3)(e): Ensure review of the effectiveness of care occurs including through reassessment following incidents, changes and deterioration of consumers.

**Standard 3 Personal care and clinical care:**

Requirement (3)(a): Ensure consumers receive safe and effective personal care and clinical care including pain management, medication management and falls management which is in line with best practice and the organisation’s policies and procedures.

Requirement (3)(b): Ensure each consumer’s high impact and high prevalence risks are managed effectively including management of pain, falls and unexplained weight loss.

**Standard 6 Feedback and complaints:**

Requirements (3)(c) and (3)(d): Ensure all complaints are actioned and recorded on the complaint register to monitor appropriate actions occur, trends are identified and areas for improvements in care and services are identified.

**Standard 8 Organisational governance:**

Requirement (3)(d): Ensure the service effectively implements and applies the organisation’s risk management framework effectively, including in relation to risks associated with falls and malnutrition.

Requirement (3)(e): Ensure clinical governance framework in relation to minimising use of restraints and open disclosure is applied effectively. Ensure ongoing monitoring of governance systems identifies and actions any deficits or areas for improvement.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

This Quality Standard is Compliant as six of the six Requirements have been assessed as Compliant.

The service was found Non-compliant in Requirement 1(3)(a) following the Assessment Contact conducted from 16 March to 17 March 2022. Since March 2022 the service has undertaken initiatives to address the deficits which the Assessment Team found have been effective and rectified deficiencies identified at the Assessment Contact in March 2022.

Consumers reported they are treated with kindness, compassion and understanding by staff and they are able to maintain social connections and engage in activities that bring them joy and purpose. Consumers confirmed they are treated as an individual with unique needs and preferences.

Staff said they provide appropriate and respectful care to all consumers regardless of their cultural background. Staff receive cultural safety training so they understand and respect the cultural differences of the consumers they are caring for. The service provide meals that reflect the cultural dietary needs of consumers, and consumers confirmed they are encouraged to maintain their cultural practises and traditions such as religious observances and ceremonies.

The service encourage consumer and family to participate in decision-making and care planning with respect to consumers culture, beliefs, values, personal, clinical care and lifestyle.

Staff described how they encourage consumers to maintain their independence and autonomy by providing opportunities for them to make decisions and choices about their own care and daily activities. The service has open communication and transparency with consumers and their families about the risks and benefits of different activities and interventions involving them in the decision-making process and encourage them to take risks in a safe and controlled environment. Care plans are regularly reviewed and assessed for each consumer to ensure they are taking appropriate risks, and adjustments are made as necessary.

There are policies and procedures in place to protect the privacy and confidentiality of consumers personal and medical information, and all staff members are trained on these policies and procedures and understand the importance of maintaining consumers confidentiality. There are measures in place to protect consumers’ personal and medical information such as password protected electronic records and secure storage of paper records.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 2(3)(a) and 2(3)(e) are Non-compliant.

The service was found Non-compliant in Standard 2 Requirements 2(3)(a) and 2(3)(d) following the Assessment Contact conducted from 16 to 17 March 2022. The Non-compliance was due to the service being unable to demonstrate effective assessment and monitoring of consumers with changed clinical needs and not communicating outcomes of assessment and planning to the consumer and/or their representative.

Since March 2022, the service has undertaken and is in the process of implementing initiatives to address the deficits including the following:

The service is planning to initiate a “Resident of the day” assessment process. This will include a record to check consumer’s information, including weight, blood pressure and that assessments are up-to-date.

The service has commenced a meeting to review and discuss falls where falls are holistically reviewed.

The Assessment Team found improvements have been ineffective and recommended Requirement 2(3)(a) as Not Met because the service is not undertaking assessment and planning that includes consideration of risks and informs safe and effective care services. Although assessment information is gathered, it is not effective in identifying risk and implementing strategies to minimise risk. This includes assessment and planning of care and risks associated with chemical restraint and poor nutrition. The Assessment Team’s report provided the following evidence relevant to my finding:

Whilst one consumer’s psychotropic medication was increased to manage changed behaviours, a relevant Health Management assessment was not completed accurately and did not include any information regarding monitoring of the effectiveness of the medication change and changes in the consumer’s behaviour.

Whilst the second consumer was 10kg below their desired weight, the assessment findings were not used to implement nutritional assistance in line with the service’s processes which includes a regular protein supplement. The consumer lost 7kg over the past four months, but a recent Nutritional Assessment did not identify any strategies to reduce the risk of malnutrition.

The effectiveness of ‘as required’ medication was not assessed for two consumers in line with the policies and procedures.

The provider has committed to addressing the deficits identified including ensuring consumers have appropriate assessments completed and provided additional information as well as plan for continuous improvement. The information and evidence includes, but is not limited to, the following:

Education on assessment and monitoring associated with the administration of ‘as required” psychotropics medication is in progress.

Relevant Health Management assessments have been reviewed and updated.

The consumer is now accepting protein supplements.

Based on the Assessment Team’s report and the provider’s response I find the service Non-compliant with this Requirement. I acknowledge the provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team.

However, I find at the time of the Site Audit the service did not demonstrate assessments and planning is effective, including around assessment of risks associated with chemical restraint, nutrition and pain. The service did not demonstrate outcomes of assessments are consistently used and reviewed to inform current strategies on the consumers’ care plan so that safe and effective care is delivered to each consumer.

In coming to my finding in relation to this Requirement, I also considered information and evidence presented in the Assessment Team’s report in Requirement 3(3)(a) and 3(3)(b), specifically in relation to deficiencies in pain assessment for two consumers who have not had their pain monitored in line with the care plan directives and policies and procedures.

I considered the service did not assess nor monitored Consumer A’s pain to ensure their pain management is effective. Directives of completing pain monitoring chart every shift post-surgery was not followed. The only pain assessment was conducted by the physiotherapist when the consumer entered the service. There have been no further pain assessment following the consumer’s fractured clavicle in July 2022 and numerous falls. The provider’s response included plan for continuous improvement and actions to address deficits in assessment and planning, including ongoing pain education for staff in relation to pain identification, completion of pain assessments and planning, review of current pain management for consumers at risk who are not responding to pain management treatment plan.

The Assessment Team recommended Requirement 2(3)(e) as Not Met because it found the service is not always reviewing consumer’s care in response to changes in consumer’s condition to ensure safe and effective care. The Assessment Team’s report provided the following evidence relevant to my finding:

One consumer’s mobility has not been assessed following a fracture as the care plan states the consumer requires one person to assist while walking. At the time of the Site Audit the consumer required a full hoist for transfers and no longer walked.

Regular review of restrictive practice is not conducted following changes to a consumer’s condition. One consumer had no review of his psychotropic medication following ongoing falls.

Behaviour support plans have not been updated to include information regarding restrictive practice for three consumers and consumers/ and or consumers’ representatives were not involved in the review of behaviour support plans.

The provider has committed to addressing the deficits identified including ensuring consumers have appropriate assessments completed and provided additional information as well as plan for continuous improvement. The information and evidence includes, but is not limited to, the following:

The consumer’s care plan has been updated to reflect their current mobility.

Staff training to promote appropriating consisting updating of all aspects of care plan has been provided.

Behaviour support plans will be updated as a priority for three identified consumers, and consumers’ representatives will be invited to have a discussion in relation to this.

Consumers’ psychotropic medications have been reviewed and were trialled to be reduced.

Based on the Assessment Team’s report and the provider’s response I find the service Non-compliant with this Requirement. I acknowledge the provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team.

However, at the time of the Site Audit the service did not demonstrate consistent staff practices in relation to reviewing consumer’s care in response to changes in consumer’s condition to ensure safe and effective care. Staff do not always update the consumers’ care plans as the consumer’s condition and circumstances, such as mobility and medications, change. Staff do not regularly review consumer care plan to ensure it is still appropriate and effective for the consumer’s needs and that is meets consumer goals.

Based on the summarised evidence above I find Requirement 2(3)(e) Non-compliant.

I am satisfied Requirements 2(3)(b), 2(3)(c) and 2(3)(d) are Compliant.

Generally, consumers are involved in the assessment and care planning process and their input is sought and valued throughout the process. Staff provided examples of how they communicate effectively with other service providers involved in the care of the consumer, such as doctors and nurses and therapists to ensure that everyone is aware of the consumer’s care needs and goals. The service has a referral system and processes in place. However, due to the service being in a regional location some services are not easily accessible, including speech pathologist, dietician and podiatrist.

Care plans are regularly reviewed and updated to reflect consumer’s needs, goals and preferences including in relation to advance care. Consumers confirmed they are provided with adequate information and support to make informed decisions about their care including advance care planning.

This service hold regular meetings with the consumer and their family members to discuss the consumer care plan. Consumers confirmed the service regularly communicate with them to keep them informed about their care. The service ensures outcomes of the care planning are available to the consumer and their family members upon request.

The service makes referrals to other care providers to review and make recommendations in consumer care needs. Consumers’ care and services plans are documented and accessible to staff, and representatives when they request further review. Consumers communicate their preferred decision-maker, and staff undertake conferences with the decision-maker as required.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 3(3)(a) and 3(3)(b) are Non-compliant.

The service was found non-compliant in Requirements 3(3)(a), 3(3)(b), 3(3)(d), and 3(3)(e) following the Assessment Contact undertaken from 16 to 17 March 2022. Since March 2022, the service has undertaken initiatives to address the deficits identified, including:

The service has had training to improve wound care. Wounds reviewed by the Assessment Team showed wound assessments were completed and wound care undertaken according to directives. Wounds were measured and photographed.

The service is initiating a new improvement. An alert’s process is being initiated to alert staff to tasks that require daily monitoring. This initiative is planned to improve pain assessment and charting by trained staff initially and is currently being rolled out.

Whilst the service showed improvements in how 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 improvements have been ineffective to ensure Compliance in Requirements 3(3)(a), 3(3)(b) and 3(3)(d).

The Assessment Team recommended Requirement 3(3)(a) as Not Met specifically in relation to ineffective provision of best practice pain management, chemical restraint and post fall monitoring of a consumer’s observations. Whilst the service has policies and procedures in relation to best practice clinical care, including pain, restrictive practices and post fall management, these are not consistently followed by staff. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two consumers have not had their pain monitored in line with the care plan directives and policies and procedures. Staff said the first consumer may have pain during care and on movement and the second consumer displayed signs of pain on one occasion during a dressing change.

Three consumers have not had weekly review of their care where medications were prescribed as chemical restraint. The policy states the use of each consumer’s specific restrictive practice should be reviewed on a weekly basis to determine the practice is still required and being managed effectively.

Three consumers did not have their full set of observations, including neurological observations, completed according to the service’s policies following an unwitnessed fall. Observations undertaken following an unwitnessed fall were generally blood pressure and pulse only.

The provider has committed to addressing the deficits identified including ensuring consumers have appropriate assessments completed and provided additional information as well as plan for continuous improvement. The information and evidence includes, but is not limited to, the following:

* Continuing education is being carried out as per the service’s continuous improvement training plan to ensure consumer care plans are updated and reflect individual needs and assessments for optimising health and well-being.
* Greater emphasis is placed on the use of vital consumer information to reflect frequency of observations post fall, behaviour assessment, psychotropics medication register and Resident Medication change documentation. Education commenced at clinical meetings.

Based on the Assessment Team’s report and the provider’s response I find the service Non-compliant with this Requirement. I acknowledge the provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team.

I have considered poor assessment of pain and monitoring of the effectiveness of the pain management plan under Standard 2 Requirement 2(3)(a). Standard 3 relates more directly to the care received by the consumers. While failure in relation to planning and assessment might not amount to serious risk, the resulting care outcomes as assessed under Standard 3 could.

I have considered the Assessment Team report and the provider’s response in relation to Consumer A mentioned in Requirement 3(b). The pain chart attached to the provider’s response shows the consumer displayed and complained of unmanaged pain for several days until they were reviewed by the general practitioner. Pain charts records include statements on 7 July 2022 that the consumer was screaming when staff attempted to move and change the consumer, that the consumer has a history of 3 recent falls and needs urgent medical review. The consumer continued to display signs of pain and complain of pain with staff recording on 13 July at 4:00Pm, the consumer was ‘very sore’, had facial grimacing and unable to raise arm without being un pain. Doctor’s notes attached to the provider’s response shows, the doctor reviewed the consumer on 14 July 2022, reviewed and changed the consumer’s pain-relieving medication and commenced the consumer on a new medication for pain management. The doctor noted the consumer had a fall onto left shoulder on 13 July 2022 and a clavicle facture was suspected.

I am concerned, Consumer A had a significant pain in their shoulder which was not managed effectively for at least 8 hours from when they fell to when they were reviewed by the doctor and additional pain relief was prescribed.

Chemical restraint is not managed in line with the best practice principles and the organisation’s policies and procedures, such as regularly reviewing of the effectiveness of the restraint and considering discontinuing the restraint if it's no longer necessary. Lastly, best practise for post fall monitoring is not followed, including assessing the consumer’s vital signs and assessing neurological function immediately following the fall and regular intervals afterwards.

Accordingly, I find the provider is Non-compliant with the Requirement 3(3)(a).

The Assessment Team found Requirement 3(3)(b) Not Met because they found high impact risk, including associated with chemical restraints and falls are not management effectively. Three consumers had restrictive practices in relation to chemical restraint that was not used as the last resort, or for as short a time as possible. The Assessment Team’s report provided the following evidence relevant to my finding:

* Whilst Consumer A was identified by the service at a high risk of falls, with a history of two fractures in the past five months (clavicle and neck of femur), three psychotropic medication that have a high potential for harm due to their possible side effects have not been trialled for a dose reduction since the consumer entered the service in June 2022. In addition, following one of the falls, the consumer had unmanaged pain that was not recognised due to the service relating change in behaviours, such as screaming and being agitated, to the recent change in the psychotropic medication dosage.
* Consumer A’s mobility status changed from being able to walk on admission to being unable to walk within 5 months due to two fractures. The ‘as required’ medication was administered to the consumer on 3 occasions in October 2022 due to the consumer being restless and agitated. The effectiveness of the medication was not recorded according to the service’s policies and procedures.
* Consumer B was prescribed ‘as required’ psychotropic medication that had no information on why it was introduced. The consumer had the ‘as required’ medication administered overnight on 4 occasions due to their restless behaviours and no other strategies were applied prior to administration of the medication. The consumer’s representative was not aware a chemical restraint has been commenced.
* Consumer C had their psychotropic medication increased since entering the service. Although the service had recommendations from Dementia Services Australia in ways to support the consumer with their changed behaviours, the service has not trialled the recommendations to reduce risk of harm. The consumer’s representative advised whilst they were informed of a medication change, they were not advised why it was necessary.
* Consumer D has had a high number of falls. Despite the high risk of falls, the service has not ensured the consumer’s risk of a having a further fall is minimised with the wearing of the right knee brace according to the consumer’s care plan. In addition, the consumer’s pain following the falls was not monitored. Allied health staff and the Assessment Team noted the consumer had pain on standing and movement. The consumer confirmed they had pain in their knee.

The provider’s submitted a response the Assessment Team’s report and while the provider acknowledges the gaps identified in the report, does not agree with all the findings in this Requirement. The provider has commenced an action plan to address the gaps identified by the Assessment Team and have provided further information and improvement actions which include, but are not limited to:

* Consumer A was prescribed psychotropic medication (antipsychotic) at a hospital prior to the entry into the service. Hospital records were attached to the provider’s response to demonstrate this. The provider maintains the consumer was not administered any ‘as required’ analgesia and maintains this was due to the Assessment Team confusing information with records for another consumer.
* Consumer B was prescribed psychotropic medication to reduce the symptoms of Parkinson's disease not as a chemical restraint. Relevant documents are attached to the provider’s response showing regular medication was prescribed for long term use to specifically manage uncontrollable shaking episodes associated with Parkinson’s disease.
* The provider refutes the Assessment Team’s finding that Consumer C did not participate in activities recommended by the external service provider. There are gaps in participation due to COVID outbreaks and lockdowns.
* Consumer D refuses to wear a support knee brace and removes it if staff assist the consumer to put it on. Multiple family conferences have been conducted where management strategies to reduce the risk of falls were discussed and the consumer’s non-compliance with wearing a knee brace and using call bell.

Based on the Assessment Team’s report and the provider’s response I find the service Non-compliant with this Requirement.

I find the service did not demonstrate best practice strategies are put in place to effectively manage risks associated with the following:

* chemical restraint, such as ensuring it is used as a last resort after exhausting non-pharmacological strategies;
* unmanaged pain leading to an increased risks of falls; and
* unplanned consecutive weight loss.

I considered Consumer A’s falls risk were not managed effectively. Hospital discharge notes attached to the provider’s response show the consumer was known to have a high falls risk. I am satisfied the consumer’s medications were administered at the service as prescribed by the specialised mental health service provider where the consumer was receiving treatment prior to coming to the service. However, I considered the service did not successfully implement falls risk mitigation strategies resulting in multiple falls and 2 fractures within a short period of time since the admission to the service. As a result, the consumer is now unable to mobilise.

In relation to Consumer B, I find on at least 4 occasions sedative medication was not administered as prescribed, that is to manage uncontrollable shaking rather to settle the consumer when they were agitated and trying to get out of bed which is indicative of staff trying to modify the consumer’s behaviour.

In relation to Consumer C, in its response in relation to consumer psychotropic medication they provider states in Requirement 2(3)(e) that an antidepressant had been increased for behaviours associated with the consumer’s behaviours which indicated that depression was not appropriately managed. As a result, the treating General practitioner increased antidepressant medication dose. However, progress notes from the general practitioner attached to the provider’s response shows the medication was increased due to staff raising concerns with the general practitioner in relation to behavioural problem—aggression.

I consider the provider did not ensure non-pharmacological strategies were trialled to manage Consumer C’s changed behaviours, hence to minimise an increased risk of falls. The activity participation records attached to the provider’s response does not show any activities or best practice non-pharmacological strategies trialled prior the increase in the medication to manage increased aggression.

In addition, I considered evidence and information in Requirement 3(3)(d) in relation to the consumer’ unexplained weight loss and how risks associated with this were not managed effectively. The Assessment Team found the consumer has not been offered any supports to reduce their risk of further deterioration due to significant weight loss. The provider responded by stating the consumer is now receiving a nutritional supplement and prior refusal of supplement has contributed to the consumer’s weight loss.

I consider at the time of the Site Audit the service did not manage the consumer’s risks associated with ongoing weight loss effectively because they clinical staff did not take actions in response to the consumer’s refusals of nutritional supplements commenced by the service in response to the consumer’s reduced oral intake and ongoing weight loss.

Accordingly, I find the provider is non-compliant with the Requirement 3(3)(b).

The Assessment Team recommended Requirement 3(3)(d) as Not Met because they found the service did not respond to deterioration or changes in two consumers’ health related to loss of weight and pain management. The Assessment Team’s report provided the following evidence relevant to my finding:

* Whilst staff referred a consumer to a speech pathologist and a dietician appropriately in response to the consumer’s unplanned weight loss and completed a relevant assessment, it failed to monitor food and fluid intake chart. Clinical staff did not take actions in response to the consumer’s refusals of nutritional supplements commenced by the service in response to the consumer’s reduced oral intake.
* Staff did not monitor the second consumer’s pain daily as per the directive to ensure analgesia prescribed by a general practitioner in response to the change of the consumer’s condition was administered appropriately. Staff reported consumer was in pain during the recent dressing change. Staff was notified about the requirement to monitor the consumer’s pain daily. However, this has not been followed by staff due to misinformation that occurred with trained staff with regards to new system to alert staff when pain assessment is required.

The provider responded by providing clarifying information and supporting evidence, including the following:

* In relation to the first consumer with an unplanned weight loss, the provider states the consumer is now accepting nutritional drink and a dietitian appointment was booked for December 2022. The provider states prior refusal of supplement has contributed to the consumers weight loss.
* On 17 November 2022, an educational session was provided for nursing staff by residential care line outreach service on assessing an management of deteriorating consumer.
* In relation to the second consumer, a nurse has made a clinical decision to complete wound care which required a single swipe to remove slough before applying a dressing. The consumer would have been at higher risk, had the dressing being delayed whilst waiting for analgesia to take effect. The nurse made the decision not to administer analgesia prior to the wound dressing based on having previously completed the procedure without any indication of pain from the consumer. The provider attached a wound management plan to its response to support its claim of the consumer have not had unmanaged pain.

I came to a different view from the Assessment Team and find the service is Compliant with Requirement 3(3)(d). I consider the service demonstrates 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. I acknowledge difficulties with accessing services of a speech pathologist, dietician and podiatrist due to the service being in a regional location.

In relation to the consumer’s management of pain, I consider the consumer’s change in condition was recognised and responded to appropriately. I have considered wound management plan attached to the provider’s response that shows the consumer was regularly monitored by clinical staff who assessed the consumer’s condition every day during a dressing check. I consider a failure to document pain assessment is more relevant to the Requirement 2(3)(a) where it was considered. I acknowledge the consumer had pain on one occasion during the dressing change, however, I do not consider this is indicative of ineffective management of deterioration.

In relation to the first consumer’s unplanned weight loss, I consider information and evidence is more relevant to Requirement 3(3)(b) which I found Non-compliant.

I am satisfied Requirements 3(3)(c), 3(3)(e), 3(3)(f) and 3(3)(g) are Compliant.

Staff described how they provide physical comfort and symptom management including administering medication as needed and providing palliative care to alleviate pain and other symptoms. Staff are provided with training and support to ensure but they are equipped to provide appropriate and safe end of life care.

Regular updates about the consumer’s condition, treatment plans, goals and preferences and any changes to their care plan are documented and provided to staff within the service and with others where responsibility for care is shared. Effective information sharing is achieved through several ways, including face-to-face conversations, phone calls, notes, emails, electronic medical records and team meetings.

Clinical staff make appropriate referrals to other providers of care including the doctor, speech pathologist, physiotherapist and dietician. The service has a system to refer consumers identified with swallowing deficits to the speech pathologist and referral to the dietician is undertaken for weight loss. Due to regional location the service experiences difficulties with accessing a dietician for referral for nutritional needs, and a podiatrist.

The service uses standard precautions to prevent and control infection. Appropriate antibiotic prescribing is used to reduce the risk of antibiotic resistance. Staff have infection control training at commencement of employment, and annually. Additional training has been provided during the COVID-19 pandemic including donning/doffing of personal protective equipment. The service has policies and procedures regarding minimisation of antibiotic prescribing and staff said they understand pathology testing should always be conducted before antibiotic prescription.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Quality Standard is Compliant as seven of the seven Requirements have been assessed as Compliant.

Consumers reported they are provided with opportunities for socialisation and connection such as group activities, events and outings as well as opportunities for communication and connection with friends and family. Consumers interviewed said their services and supports are consistent as they are mostly looked after by regular staff who are aware of their preferences and routines.

Staff described how they work with consumers to identify and support their personal interests and hobbies and provide resources and opportunities for consumers to continue to engage in activities that they enjoy. Consumers have access to various therapy services including physical therapy, occupational therapy and speech therapy to help them maintain their physical and cognitive abilities.

The activity program includes seasonal and cultural events and activities to meet the consumers’ cultural, religious and spiritual background. These include theme days, Anzac Day, Easter, Mother’s Day, Father’s Day and Melbourne Cup. Non-denominational church services are conducted every Sunday and a priest from the local catholic parish visits consumers on Fridays.

The service provides a varied menu that takes into account the dietary needs and preferences of consumers including options for different cultural and religious backgrounds meals are prepared on-site which helps to ensure that meals are fresh and of high-quality consumers are offered alternatives with special dietary needs not the menu is regularly reviewed and adjustments are made to meet the needs and wants of the consumers.

The service has a clear process in place for making referrals and staff were able to describe when and how referrals are made and who is responsible for making them. Consumers have access to community-based services and programmes that can help consumers with maintaining their independence and quality of life. Consumers are provided with equipment that is appropriate for their abilities taking into consideration a range of factors such as mobility, dexterity and cognitive function. There are systems and processes in place to ensure equipment is regularly reviewed and updated to ensure that his current and meets the needs of consumers.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

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

The service has a homely environment, all rooms consisting of single bedrooms with ensuite. All wings have their own separate dining areas and separate lounge/sitting areas. Two memory support wings have different colour doors leading into consumers bedrooms to assist them to navigate the service and locate their bedrooms with ease. The service permanently keeps chickens and a cat for a companionship and interaction. The reception area is located next to the main entrance, and on arrival all visitors were observed to be greeted and supported to navigate the service by a staff member.

Consumers reported they feel secure and comfortable in their living environment with appropriate facilities and amenities, they have access to familiar items and belongings to make the environment more familiar in comfortable and they are encouraged to decorate and personalise the living space to make it feel like their own. Consumers were observed to move freely, both indoors and outdoors.

The service environment is safe, clean and well-maintained and this is achieved through a range of measures including regular cleaning of all surfaces and common areas, regular maintenance of all equipment and facilities, regular safety inspections to identify an address potential hazard and providing necessary equipment and supplies to staff.

Staff provided examples of how they maintain safety and cleanliness of the environment through the proper use, maintenance and storage of equipment and supplies, and the proper cleaning and disinfection of the surfaces and equipment.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 6(3)(c) and 6(3)(d) are Non-compliant.

The Assessment Team recommended Requirement 6(3)(c) as Not Met because the service did not demonstrate appropriate action is taken in response to complaints. The Assessment Team’s report provided the following evidence relevant to my finding:

A review of 11 complaints and 15 suggestion feedback forms completed by consumers, representatives and staff did not have any evidence of acknowledgement, response or follow up as per the organisation’s feedback and complaints policy.

One consumer representative advised they had not received any feedback following their written complaint made in October 2022 in relation to the failure of the service to involve them in the decision-making process associated with the planning and delivery of care.

Two consumers advised they have not received any feedback in relation to the written complaints about food submitted in August 2022.

The provider disagreed with the Assessment Team’s findings and provided information that disputes the conclusion reached, including the following:

The lack of written evidence of actions following up on complaints is purely a lack of time available by management and other work that had higher priority.

The provider acknowledge the failure to document action, however asserts every complaint was actioned.

The complaints related to the evening meal were followed up by management with a hospitality staff member at which time they were instructed to follow up with the consumers. The staff member informed management communication had taken place with the consumers; however no documentation was done to record the conversation.

* In relation to the complaint of the representative about the failure of the service to involve them in the decision-making process associated with the planning and delivery of care,

an assumption was made that one of the key personnel would speak to the representative asking them to come speak to management. Since the representative had not made contact with management, a follow up conversation had not yet taken place. The lack of documentation around follow up on this complaint is purely as a result of the action still being followed up.

The provider is planning to contact the representative to offer them the opportunity to discuss their complaint.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate effective systems in place to make sure complaints are followed up and appropriate action is taken.

The provider asserts all written complaints reviewed by the Assessment Team have been fully investigated and followed up. However, in its response, they were unable to provide any documentation or evidence to support that follow up had taken place on all complaints. This raises concerns about the thoroughness and effectiveness of the complaint handling process.

I have considered a lack of follow up on the consumer representative’s complaint for over the month since the complaint was lodged could reasonably have resulted in the service missing out on the opportunity to improve their systems and processes any relation to involving relevant people in the decision-making process related to care and services.

Whilst the provider asserts food related complaints from the two consumers identified in the Assessment Team’s report have been followed up, its response does not include any documentation or evidence to support that follow up had taken place.

Accordingly, I find the provider is Non-compliant with Requirement 6(3)(c).

The Assessment Team recommended Requirement 6(3)(d) is Met. The Team’s finding was based on the following information and evidence:

Consumers said that although not all current feedback and complaints have been considered, they felt that the service uses the complaints and feedback system to improve the care and services.

The service has a continuous improvement plan to documents improvement that have come from feedback and complaints.

Staff say that not all complaints and feedback are responded to appropriately, so some items are not considered.

One consumer provided an example of an improvement in care and services delivery as a result of their feedback.

The service installed additional feedback letterboxes throughout the service in response to the suggestion provided through feedback forms.

One staff member stated they had made a suggestion for improvements but said it has not been followed up as yet and it was one of the forms reviewed by the Assessment Team that had not been actioned.

Management stated that whilst there have not been any recent items added to the continuous improvement plan, it is only due to the staff member who completed the monitoring the process resigning.

Based on the evidence and information summarised above and information and evidence presented in the Assessment Team’s report in Requirement 6(3)(c), I came to a different view of the Assessment Team and find Requirement 6(3)(d) Non-Compliant.

I consider, there is a system in place for tracking and documenting feedback, however the service did not demonstrate that the data is regularly reviewed and analysed to identify trends and areas for improvement.

Through the information provided in Requirement 6(3)(c) I was not provided any evidence to show that that complaints were being documented even though it was said they had been actioned. This would be required to effectively monitor, trend and analyse complaints, so the complaints could be used to improve the quality of care and services. Even staff had not received any feedback in relation to suggestions made to improve the care and services and there was no information provided to show that any suggestions had been implemented.

I am satisfied the remaining Requirements 6(3)(a) and 6(3)(b) are Compliant.

Consumers said they are aware of the complaints process and how to access it, including through multiple channels such as phone, email, in person and feedback forms. Feedback process at the service is included in the information brochure for new admissions and it is publicised in the newsletter.

The service provides information to staff and consumers on how to access language services, such as interpreter services, to ensure that all consumers are aware of the options available to them. Staff advised they are trained on how to handle complaints and feedback from consumers and that they are aware of the different language and advocacy services available. Consumers said the service communicated to them how to access independent advocates who can assist with raising and resolving complaints.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

I have assessed this Quality Standard as Compliant as I am satisfied five of five Requirements are Compliant.

The service was found non-compliant in Standard 7 Requirements (3)(a), (3)(c), (3)(d), and (3)(e) following the Assessment Contact conducted from 16 to 17 March 2022. Since March 2022 the service has undertaken initiatives to address the deficits including:

Employing a Training Officer who commenced on 29 June 2022.

Reintroduction and update of orientation competencies and a follow up for all new staff on the orientation competencies conducted by the Training Officer.

Amendments of training policy to include a staff bonus when all allocated training has been completed depending on the individual role.

At the Site Audit, the Assessment Team found Requirement 7(3)(c) as Not Met and previously Non-compliant Requirements 7(3)(a), 7(3)(d) are now Met.

The Assessment Team found, although consumers feel staff are trained, competent and skilled to do their job, it was not always demonstrated they followed policies and procedures. Documentation showed that whilst staff have been trained in areas such as pain management and falls management, staff did not always follow policies and procedures competently to ensure consumers receive quality care.

* Documentation showed Consumer A did not have regular pain charting completed following a surgical procedure and their mobility care plan was not updated to reflect changed needs. Management advised Consumer A’s mobility care plan had been changed and was done the first day Consumer A came back from hospital. Management explained due to the upgrade of the clinical system, the information must have been lost.

Staff did not record assessment of pain during one consumer’s wound care.

One consumer expressed pain in their leg and was observed to have pain on standing and movement.

Staff did not follow up on a speech pathologist’s referral.

Chemical restraint was administered to one consumer without a documented informed consent.

Staff did not conduct neurological observations as per the unwitnessed fall procedure for three consumers following unwitnessed falls.

Management advised said they are aware staff are not completing Neurological Observations as per the organisation’s policies and procedures post falls and they had followed this up with nurses on numerous occasions.

Management advised pain charting was missed due a new system being rolled out. They said the electronic care management system will be sending alerts to staff and this will improve monitoring of consumer’s pain.

The provider has commenced an action plan to address the gaps identified by the Assessment Team and have provided further information and improvement actions which include, but are not limited to:

Additional education and training efforts have been implemented to ensure a regular assessment of consumers is carried out as per policy and procedures.

Staff training is also being provided and post for procedure document was provided to all areas of the service to ensure observations post fall are carried out appropriately.

I came to a different view from the Assessment Team’s recommendation of Not Met and find Requirement 7(3)(c) is Compliant and the service adequately demonstrates its workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. I considered consumers’ feedback that they feel staff are trained, competent and skilled to do their job.

In coming to my finding, I have also considered information in the Assessment Team’s report across Standard 7, including in Requirement 7(3)(d) and 8(3)(c) where it is stated consumers said staff were competent and were able to provide safe care and services; staff stated they received training and education they need to provide safe and effective services and documentation confirmed staff complete orientation competencies which include mandatory training and staff are monitored to ensure they complete mandatory training and have relevant qualifications and clearances to complete their roles.

Whilst the Assessment Team found deficiencies in assessment and planning and delivery of personal and clinical care are the result the workforce incompetence, this was not supported by relevant evidence. There might be other factors that contribute to the above deficiencies, including the ones identified by the Assessment Team, such as deficiencies in information management system and lack of training. Incompetence refers to a lack of skill or knowledge in certain areas and I am not provided evidence that shows deficiencies identified in Standard 2 and Standard 3 are a direct result of the workforce incompetence.

The Assessment Team’s report does not reflect whether staff were interviewed and asked questions in relation to the intent of this requirement, such as whether they feel confident, they have the qualifications and knowledge to effectively perform their role.

Based on the evidence summarised above, I find Requirement 7(3)(c) is Compliant.

I am satisfied the remaining Requirements 7(3)(a), 7(3) (b), 7(3)(d) and 7 (3)(e) are Compliant.

Consumers and their representatives interviewed confirmed consumers receive quality care and services from staff who are knowledgeable, capable and caring. Consumers stated staff were kind and know what they are doing and there are enough staff to provide care and services when they need it.

The service demonstrated it has systems supported by the wider organisation to recruit appropriately qualified staff and on entry to the workforce training and information is provided to enable staff to perform their roles. The service has planned rosters and staff allocation based on consumer needs and vacant shifts are filled by the organisation’s staff or relief ‘agency’ agency staff if required. The service has a mix of skilled staff including registered nursing staff and additional clinical support where required.

The service has processes in place for assessment, monitoring and regular review of performance of each member of the workforce. Where indicated through incident reporting and/or feedback staff are performance managed appropriately. The service provides additional staff training where required and an annual training program is in place.

Staff interviewed confirmed they are provided training and have opportunities to provide feedback including through performance reviews. Staff confirmed they have sufficient time and information to perform their roles and are aware of their responsibilities.

# Standard 8

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

Findings

The service was found Non-compliant in Requirements 8 (3)(b), 8(3)(c) and 8(3)(e) following the Assessment Contact conducted from 16 to 17 March 2022. Since March 2022 the service has undertaken a range of initiatives to address the deficits, including:

* Recruitment of a training officer to ensure compliance with all training outcomes.
* Improvements to post admission processes and recruitment of post admission officer who completes post admission review and engages next of kin for future collaboration.
* Review and update of clinical care policies to guide staff in provision of quality care and services.
* The service formed the Clinical Governance and Risk committee in March 2022. The Committee is responsible for a provision of current and accurate clinical indicators data and risks to the Board of members.
* Staff members were provided a variety of training, including antimicrobial stewardship, open disclosure, abuse, unexplained absences and serious incidents response scheme.

At the Site Audit, the Assessment Team found previously Non-Compliant Requirements 8(3)(b) and 8(3)(c) are now Met. However, Requirements 8(3)(d) and 8(3) (e) were found Not Met.

Whilst the service showed effective governance systems in relation to identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can, it was not able to demonstrate the effective risk management systems and practices, including managing high impact or high prevalence risk, identified and engaged strategies to reduce the risks to each consumer. In addition, the service has incident management system, that captures incident data including from reportable incidents to analyse trends, however it does not always use this information to improve care and services in relation to high impact and high prevalence risks.

* One consumer has had multiple falls since entry into the service resulting in two fractures and loss of mobility. Despite known high falls risk and injuries sustained as a result of falls, the service did not implement effective falls preventive strategies and did not mitigate the risk of falling and the risk of injuries from falls.
* One consumer has sustained ongoing weight loss over four months period. However, no effective risk assessment occurred to understand the risks to the consumer associated with ongoing weight loss and no risk mitigation strategies were put in place to minimise impact from the significant weight loss.
* There were two similar medication incidents related to two different consumers of a similar nature where in one instance a palliative medication was almost administered without appropriate consultation and consent. The service did not put appropriate actions in place following this incident and did not review the effectiveness of its risk management system associated with medication management. As a result, the second similar incident occurred where a consumer was given ‘as required’ medication as a chemical restraint without appropriate consent obtained prior to it.

The provider responded by stating:

* In relation to a medication incident related to a palliative care medication, staff did not administer palliative medications due to adhering to policy and checking procedures that are in place to prevent such an error. The family was not notified as the decision was made not to administer the medication.
* In relation to the second consumer, they were prescribed anxiety medication to reduce the symptoms of their Parkinson’s disease and it was not a chemical restraint.

I have considered the Assessment Team’s report and the provider’s response and find the service is unable to demonstrate effective risk management systems in place specifically in relation to management of risks associated with falls and malnutrition.

I have not been provided enough evidence and information to form a view on the effectiveness of the organisation’s incident management system.

In coming to my finding about this Requirement, I have considered risks management systems and processes in relation to the care provided to the consumers are not effective, as whilst the service generally identifies risks, including in relation to falls and nutrition, it does not implement risk mitigation strategies tailored to the consumers’ needs. As a result, one consumer sustained multiple falls within a short period of time since admission to the service and lost their mobility due to fractures. No effective risk mitigation strategies were put in place to prevent poor health outcomes as result of consecutive significant weight loss of the second consumer.

I consider risk management strategies were effective in preventing a palliative medication from being administered without appropriate consent and decision-maker involvement.

I considered information in relation to chemical restraint under Standard 8(3)(e) where it is more relevant.

The Assessment Team recommended Requirement 8(3)(e) as Not Met because whilst the service was able to demonstrate they have effective governance framework in relation to antimicrobial stewardship, it did not demonstrate effective clinical governance framework in relation to minimising use of restraints and open disclosure. The service does not have up to date and accurate chemical restraints register and does not follow their procedural and legislative requirements for consumers subjected to environmental and chemical restraints. Four staff members from various disciplines were unable to clearly explain open disclosure principles and its appropriate use.

* The service acknowledged they did not discuss and obtain consent from 15 consumers and/or their representatives for the use of environmental restraint.
* Three consumers who are prescribed and/or administered psychotropic medication as a chemical restraint, did not have evidence of appropriate consent and evidence of non-pharmacological strategies trialled prior to the administration of a chemical restraint.
* Whilst the service has an open disclosure policy and all staff received training, four out of seven staff members interviewed were unable to clearly explain open disclosure principles and its appropriate use. The review of incident documentation, feedback and suggestions forms could not confirm that service apologises to consumer and /or next of kin when things go wrong.

The provider’s submitted a response the Assessment Team’s report and while the provider acknowledges the gaps identified in the report, does not agree with all the findings in this Requirement. The provider has commenced an action plan to address the gaps identified by the Assessment Team and have provided further information and improvement actions which include, but are not limited to:

* The Chemical restraint register has been updated to reflect accurate data.
* Family of identified consumers were consulted in relation to the use of chemical restraint.
* The service asserts, one of the three mentioned consumers was prescribed a psychotropic mediation to reduce the symptoms of their Parkinson’s disease and not as a chemical restraint.
* Ongoing training for open disclosure will be continued as per the organisation’s policy and training plan.

I acknowledge the provider’s response and actions planned and implemented to rectify deficiencies in this Requirement. However, I find at the time of the Site Audit, the service did not demonstrate effective clinical governance framework in relation to minimising use of restraints and open disclosure.

The service did not have a robust system in place to ensure appropriate consent is taken prior to the demonstration of restrictive practices and where restraint it used, the service does not ensure it is used as a last resort.

The providers asserts for one of the mentioned in the Assessment Team’s report psychotropic mediation was used to reduce symptoms of Parkinson’s disease, and a review of evidence attached to the provider’s response confirms this claim and shows a regular psychotropic medication was prescribed for long term use to specifically manage uncontrollable shaking episodes associated with Parkinson’s disease.

However, I disagree with the provider’s statements that the abovementioned consumer was not a subject of chemical restraint. As outlined in Standard 3, this consumer was administered ‘as required’ dose of the same medication on three occasions when the consumer was trying to get out of bed and was restless. I consider on three occasions the consumer was administered mediation with the main purpose of influencing the consumer’s behaviour which falls under the definition of chemical restraint.

I have also considered open disclosure framework is not effective because it does not ensure apologises to consumer and /or next of kin when things go wrong.

I am satisfied remaining three Requirements are Compliant.

Whilst the service has been unable to hold monthly Residents and Relative meetings and Food Forum meetings regularly due to COVID-19 outbreaks, they were able to demonstrate that consumers are engaged in the development and delivery of care and services. Consumers confirmed these forums have been effective in making changes to care and services and

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The service has systems in place to collect and analyse clinical data and risks and presents this information to the Board monthly. The Board is aware of current risks and takes appropriate actions to rectify these in a timely manner.

The service established Clinical Governance and Risk committee in March 2022. The committee includes a member of a Board who has a clinical background and senior clinical management staff. The committee collates all clinical indicators and risks the week prior to the board meeting and presents this information to the Board.

There are effective governance systems to ensure information is available for staff and consumers. The continuous improvement is effective system along with sound financial systems. There is a workforce governance system that oversees the workforce and a regulatory compliance is effective. Whilst there are issues with complaints and feedback, the overall governance system is effective.

The service has current continuous improvement plan that demonstrates areas for improvement are captured from a variety of sources and include timeframes for completion and a name of the person responsible. However, the plan did not capture any areas for improvement identified through clinical data indicators or feedback and complaints made by consumers and/or their representatives.

The organisation monitors changes to legislation and regulations and provides this information to staff through emails and at staff meetings.

Whilst complaints have not been actioned since the assigned person left the service in August 2022, the overall governance system is effective when they are being actioned. Prior to August 2022 the complaints policy was being followed, complaints were monitored with outcomes feeding back into the continuous improvement system.

1. The preparation of the performance report is in accordance with section 40A the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)