Performance

Report

**1800 951 822**

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| Name of service: | Fairview Inc |
| Service address: | 30 Sargeant Street WARRAGUL VIC 3820 |
| Commission ID: | 3070 |
| Approved provider: | Fairview Village Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 November 2022 to 22 November 2022 |
| Performance report date: | 15 December 2022 |

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

**This performance report**

This performance report for Fairview Inc (**the service**) has been prepared by L Glass delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* The service was issued a Directions notice on 4 May 2022 to revise the plan for continuous improvement for the service after a finding of non-compliance with the Quality Standards in Standard 2, Requirement 2(3)(a), Requirement 2(3)(d), Standard 3, Requirement 3(3)(a) and Standard 8, Requirement 8(3)(c) at a site audit in February 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 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. | 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 |

Findings

The service was found non-compliant in Standard 2, Requirement 2(3)(a), Requirement 2(3)(d), during an assessment contact in February 2022 when the service was unable to demonstrate:

* assessment and planning were effectively implemented and considered risks to the consumer’s care, health and well-being, specifically on entry to the service and in order to enable effective interventions in a timely manner.
* a process was in place to inform consumers and representatives they are able to access the care plan
* consumer’s care plans were readily accessible to them.

The scope of this assessment contact was to assess the service’s progress in returning to compliance with these requirements.

At the Assessment Contact on 21 November 2022 to 22 November 2022 the service the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit. The service demonstrated assessment of identified risks for sampled consumers who had entered the service for respite and/or a view of transitioning to long term care. Six of 6 assessment and care planning documents showed identification of risks with corresponding assessments. Initial assessment and care plan documentation outlined provision of individualised care for each consumer. Staff demonstrated knowledge of risks for consumers consistent with care planning documents and handover sheet information. The Assessment Team sighted examples of ‘pre-admission and admission checklists’ for consumers entering the service on respite and for long term care.

Staff discussed planned care strategies with consumers and representatives when making changes to care and services. Outcomes of assessment and planning are effectively communicated to the consumer and/or representative through the clinical care review process or whenever changes are required. Care plans contain language that is easy for consumers and/or their representatives to understand. The service has processes in place to inform consumers and representatives they are able to access the consumer’s care plan and ensure the consumer’s care plan is readily available; summary care plans are offered to consumers and/or representatives, via email or hardcopy and following 3 monthly care plan reviews. The 3 monthly care plan reviews will generally include clinical staff, a physiotherapist and the lifestyle team and are conducted face to face or via telephone. Consumers and representatives confirmed they are kept informed about care panning and outcomes and that care plans are made available to them.

In making the decision I have considered the Assessment Team report and the evidence that the service’s plan for continuous improvement has been implemented. I am satisfied the service has in place effective assessment and planning systems ensuring consideration of risks to the consumer’s health and well-being. I am also satisfied 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. I find Requirements 2(3)(a), 2(3)(d) are Compliant.

# Standard 3

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

Findings

The service was found non-compliant in Standard 3, Requirement 3(3)(a) during an assessment contact in February 2022 when the service was unable to demonstrate:

* that when chemical restraint was proposed the prescriber had assessed the resident, documented the reason for the restraint and informed consent was obtained
* that when chemical restraint is used monitoring and scheduled review processes are established to ensure that restraint is still needed and is the least restrictive form.

The scope of this assessment contact included assessing the service’s progress in returning to compliance with this requirement. This assessment contact was aimed to assess the service’s progress on a return to compliance in relation to the use of chemical restraint.

At the Assessment Contact on 21 November 2022 to 22 November 2022 6 of 6 consumers and representatives stated consumers receive appropriate and effective care that is important to them in relation to restrictive practices. Care planning documentation reflected assessment, monitoring, and evaluation of the use of chemical restrictive practices, including evidence of deprescribing by medical officers and/or a geriatrician. Behaviour support plans and restrictive practice assessment and authorisation forms are in place and are reviewed 3 monthly or as required. Staff described ways of minimising the use of chemical restrictive practice by using it as the last resort and ensuring non-pharmacological strategies had been trialled and evaluated prior to administration of psychotropic medications. Staff were observed interacting with consumers using personalised, non-pharmacological strategies consistent with the consumer’s behaviour support plan.

The service ensured the prescribers of psychotropic medication identified as chemical restraint have reviewed the consumer, documented the reason for the chemical restraint, and obtained informed consent from the consumer and/or substitute decision-maker. Implementation of processes for effective monitoring and scheduled review of psychotropic medications to reflect necessity, need for minimising or deprescribing, and ensuring it is the least restrictive form.

In making the decision I have considered the Assessment Team report and the evidence that the service’s plan for continuous improvement has been implemented. I am satisfied the service ensures consumers receive appropriate and effective care in relation to restrictive practices, consent is obtained that is also in accordance with legislative requirements. Monitoring and scheduled review of psychotropic medications is undertaken, and restrictive practice is minimised, and used only after non-pharmacological strategies are used consistent with the consumer’s behaviour support plan. I find the service is Compliant with Requirement 3(3)(3a).

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |

Findings

The service was found non-compliant in Standard 8, Requirements 8(3)(c) during an assessment contact in February 2022 when the service was unable to demonstrate:

* an effective governance system was in place in regard to information management and staff access to consumer care plans, handover information, policies and procedures and ensuring complaint and clinical data is available for monitoring and analysis to inform improvements to care and services.

The scope of the assessment contact was to assess the services progress in returning to compliance for requirement 8(3)(c) with a focus on 8(3)(c)(i) information management.

The Assessment Team found the service has established an effective organisation wide governance system relating to information management, including staff access to and use of consumers’ care plans to guide care, ensuring current and comprehensive handover information is available and ensuring staff have access to policies and procedures. For example:

Staff described how they do not have issues accessing consumer care plans on the organisation’s online care plan system and have access to policies and procedures online. Staff demonstrated how they access the online care plan system and policies and procedures.

Staff described how they receive comprehensive handover information before commencing each shift. Management described how the continuous improvement plan has been updated to improve the non-compliance identified in February 2022. Management described how staff have access to the online care plan system and policies and procedures online.

Management demonstrated how they have improved the layout of the daily handover sheets to include sufficient information for staff to be aware of current consumer information to inform care. Management described how information is relayed to staff through daily handover meetings, the online care plan system, daily handover sheets, staff meetings, via email or on staff noticeboards.

The Assessment Team reviewed handover documentation which included information such as consumer allergens and reactions, special needs/diagnosis, diet, emergency response, active wound locations, mobility, and restrictive practices.

The Assessment Team reviewed the service’s continuous improvement plan which identified staff have received education in relation to the online care plan system.

A review of clinical governance reporting has resulted in a new template being developed for reporting complaints and clinical data to the clinical governance committee. A review of the reporting system has been completed to ensure staff have the right authority to submit information to the Commission in relation to Serious Incident Response Scheme.

In making the decision I have considered the Assessment Team report and the evidence that the service’s plan for continuous improvement has been implemented. I am satisfied the service demonstrated an effective governance system in in place in regard to information management and staff have access to care plans to guide care, current and comprehensive handover information, policies and procedures and mechanisms to report complaints and trends to facilitate and inform improvements in consumer care. I find the service is Compliant with Requirement 8(3)(c).

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