Performance

Report

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| Name of service: | Feros Village Bangalow |
| Service address: | Cnr Bangalow Road and Ballina Road BANGALOW NSW 2479 |
| Commission ID: | 0468 |
| Approved provider: | Feros Care |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 May 2023 |
| Performance report date: | 22 June 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 Feros Village Bangalow (**the service**) has been prepared by S Turner, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives and others
* the provider’s response to the assessment team’s report received 13 June 2023
* the performance report dated 9 November 2022, for a site audit conducted 11 October 2022 to 13 October 2022
* information relating to the service history held by the Aged Care Quality and Safety Commission

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 7** Human resources | **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.

* The service is required to ensure that each consumer gets safe and effective care that is tailored to their needs and optimises their health and well-being including in relation to the management of restrictive practice and changed behaviours.
* The service is required to ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards including in relation to restrictive practices, behaviour support planning and the management of consumers with changed behaviours.

# 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 |

Findings

Requirement 3(3)(a) was found Non-compliant following a Site Audit conducted 11 October 2022 to 13 October 2022. Deficiencies brought forward involved the management of restrictive practices, specifically the documentation associated with the requirements relating to consent and authorisation.

Following the Site Audit, the organisation implemented several actions to improve its performance in relation to this requirement. Actions included the provision of staff education relating to restrictive practices and the authorisation process, and a review in November 2022 of those consumers with restrictive practices in place.

However, ongoing deficiencies relating to the management of restrictive practice were identified during the Assessment Contact conducted 23 May 2023. The service could not demonstrate that decision makers were provided with the information required to support decisions about the use of restrictive practices. Care documentation failed to demonstrate information about the intent of the restrictive practice and the risks involved with its use had been consistently provided to decision makers. Additionally, the service did not demonstrate a process for determining decision making capacity for consumers subjected to restrictive practice and management advised they were guided by recommendations from medical officers and requests from families. In response to the Assessment Team’s feedback, management advised they would contact consumers’ medical officers and undertake discussions that involved the consumer; additionally staff training would be conducted.

The Assessment Team brought forward information demonstrating deficiencies in relation to behaviour management including the development and use of behaviour support plans, behaviour charting and the evaluation of the effectiveness of medications that had been used.

In some instances, consumers who were prescribed a chemical restraint, did not have a behaviour support plan in place. Staff advised that for two consumers who were prescribed ‘as required’ chemical restraint, that this had not been used since the consumers arrived at the service. These medications were reviewed and ceased by a medical officer during the Assessment Contact.

Staff said some consumers with complex behaviours did not have a behaviour support plan in place and provided examples of consumers whose behaviours they could not effectively manage including consumers who displayed aggression towards other consumers. Documentation for one consumer demonstrated 10 documented instances of ineffective behaviour management in the previous two months. For a consumer who had a behaviour support plan in place, staff were not using established strategies when responding to the consumer’s behaviour and progress notes recorded the strategies used as being ineffective. The Assessment Team found staff did not have a sound understanding of behaviour management strategies to support some consumers with complex behaviours. Registered staff said for one consumer with changed behaviours that care staff were not sure how to manage the consumer’s behaviour and requested the administration of a chemical restraint. Management staff were aware that care staff did not have a shared understanding of behaviour management strategies and advised further education was needed in this area.

The Assessment Team reviewed reports related to the Serious Incident Response Scheme and found that strategies to mitigate the risk of further incidents of aggression were limited. Management staff advised they would refer the consumer to a dementia advisory service for an assessment and for assistance in seeking support with behavioural strategies.

The service has a policy outlining that when chemical restraint is used that staff must monitor, record and report on changes in wellbeing, adverse events, and any impact on the consumer’s ability to undertake activities of daily living. The Assessment Team found minimal evidence of this occurring in the previous month for consumers who had received ‘as required’ chemical restraint. Management was aware that monitoring processes were not effective after chemical restraint had been administered and confirmed there were deficits in associated documentation. A senior member of the clinical team stated they were requesting an alert system be added to the electronic care management system to notify and remind registered staff to monitor how mediations have affected consumers.

The Assessment Team’s report includes feedback that consumers and representatives were generally satisfied with staff, their knowledge and how they interacted with consumers. However, oweverone consumer representative, while generally happy with the care provided advised that some staff did not know how to calm the consumer when the consumer was agitated. Further, one consumer stated that following an incident of aggression from another consumer where they experienced a significant impact to their health and well-being, they were left feeling ‘quite low’ and had not received any emotional support since the incident.

The approved provider in its response to the Assessment Team’s report acknowledged deficiencies in relation to the use of restrictive practice. It stated Feros Care is implementing an education program for the residential aged care leadership and management team. In addition to this it is reviewing its policies, procedures and education materials relating to restrictive practice and reviewing all consumers who are subjected to restrictive practice to ensure appropriate consent is in place. The approved provider has said that behaviour support plans for consumers subjected to restrictive practice are to be reviewed and that staff are receiving education to ensure:

* the consistent use of strategies documented in behaviour support plans,
* that behaviours are documented, and
* the use of ‘as required’ medication as a chemical restraint is monitored.

The approved provider submitted a plan for continuous improvement that included actions that were initiated in October 2022 following the Site Audit. Planned actions were designed to ensure that the management of restrictive practices was safe and effective and optimised consumers’ health and well-being. However, the information brought forward by the Assessment Team demonstrates the actions implemented were not effective as deficiencies in the management of restrictive practices continue. I acknowledge the plan for continuous improvement has been updated on 5 June 2023. It includes plans to appoint a dementia training provider to review practices and provide staff training. Areas to address include the management of changed behaviours and the development of behaviour support plans, and the management of restrictive practices.

I am satisfied that deficiencies exist in relation to the management of restrictive practices and the management of consumers with changed behaviours. For the reasons detailed, I find Requirement 3(3)(a) is Non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements 7(3)(d) and 7(3)(e) were found Non-compliant following a site audit conducted 11 October 2022 to 13 October 2022. Deficiencies involved the staff training program and performance review processes. Staff had not completed mandatory training including in relation to restrictive practices and performance reviews were not occurring on a regular basis.

Following the Site Audit, the organisation implemented several actions to improve its performance in relation to these requirements. Actions included:

* an aged care advisory consultant assisted in the development of a restrictive practice learning module which was to be completed by all staff,
* mandatory training and competency assessments were completed by January 2023, and
* the development and implementation of a staff performance appraisal schedule.

Consumers and representatives generally spoke positively about staff, saying they were kind, capable and performed their roles well. Staff said they had completed a performance appraisal with a member of the management team and that this involved a self-appraisal component. Management said staff performance is monitored through consumer and representative feedback provided either directly to management or through consumer meetings, direct supervision of staff, incident review and staff feedback. Management described how feedback is formally and informally provided to staff. The Assessment Team found that most staff at the service had a current performance appraisal.

I am satisfied there are mechanisms in place to monitor and review the performance of the workforce and find Requirement 7(3)(e) is Compliant.

However, information brought forward in the Assessment Team’s report demonstrated staff do not have the required knowledge to consistently meet the requirements of their role, particularly in relation to the management of restrictive practices and the processes relating to the management of changed behaviours. For example:

* documentation failed to demonstrate that decision makers are consistently provided with the information they require to support decision making in relation to the use of restrictive practice
* behaviour support plans were not in place for some consumers who had been prescribed a chemical restraint
* behaviour support plans were not in place for some consumers with changed behaviours
* care staff said they did not have a shared understanding of strategies to support them in managing some consumers with changed behaviours
* care staff knowledge of how to support consumers with changed behaviours was not consistently aligned with strategies outlined in behaviour support plans
* registered nurses and management advised they were aware of inconsistencies in staff knowledge in relation to behaviour management
* senior clinical staff advised that restrictive practices education provided at the end of 2022 was not adequate and they had to undertake additional self-directed learning
* registered staff said they had not received training on restrictive practice authorisation and consent, behaviour support planning or the need to monitor and record the effectiveness of medication post administration

The approved provider in its response to the Assessment Team’s report included a plan for continuous improvement that was updated 5 June 2023. The plan included strategies to improve staff knowledge and understanding in relation to the management of restrictive practice, behaviour management and behaviour support planning. The service is seeking to appoint a dementia training provider to support staff knowledge and skill and review practices in this area.

For the reasons detailed I am satisfied Requirement 7(3)(d) in Non-compliant.

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)