Performance

Report

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| Name: | Guildford Village |
| Commission ID: | 7204 |
| Address: | 34 Swan Street East, GUILDFORD, Western Australia, 6055 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 23 July 2024 |
| Performance report date: | 21 August 2024 |
| Service included in this assessment: | Provider: 1120 Pu-Fam Pty Ltd  Service: 4732 Guildford Village |

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 Guildford Village (**the service**) has been prepared by R Falco, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the assessment team’s report for the assessment contact (performance assessment) – site, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, management, consumers, and representatives;
* the provider’s response to the assessment team’s report received 14 August 2024 where they acknowledge improvements are still required to sustainably ensure compliance against all the Quality Standards; and
* a performance report dated 24 April 2024 for an assessment contact (performance assessment) – site undertaken from 5 March 2024 to 6 March 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 8** Organisational governance | **Not 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 requirement (3)(a)**

* Ensure identified risks to clients’ health and well-being are assessed and appropriate management strategies developed and implemented to enable staff to provide quality care and services. Specifically in relation to those subject to chemical restraint.

**Standard 8 requirements (3)(d) and (3)(e)**

* Ensure effective governance systems are in place to ensure the incident management system is effective, specifically in relation to investigating the causal factors of incidents.
* Ensure a clinical governance framework is in place to effectively minimise the use of restrictive practices and provide effective oversight of the clinical care planning and risk assessment processes undertaken by staff.

# 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. | Not Compliant |

Findings

Requirement (3)(a) was found non-compliant following an assessment contact undertaken from 5 March 2024 to 6 March 2024 where it was found consideration of risks to consumers safety through assessment and planning was not demonstrated. The service implemented improvement actions, including training for registered nurses on completing care planning and risk assessments in the electronic care management system, and the implementation of the admission checklist

At the assessment contact undertaken on 23 July 2024, the assessment team recommended requirement (3)(a) not met as assessment and planning did not consider risks to consumers’ health and well-being to inform the safe delivery of care and services. A monitoring system to ensure all assessments and care plans were completed was not demonstrated and where risks were identified, risk assessment tools were not always used, or strategies implemented to inform the delivery of safe and effective care and services.

Actions in the provider’s response included, but were not limited to, developing and implementing a standard operating procedure to support clinical staff to assess and review consumers on psychotropic medications, and subject to restrictive practices.

I acknowledge the provider’s response and the actions planned and/or implemented. For the consumers identified as being at risks of falls, additional documentation was provided that showed assessments had been undertaken and strategies were implemented to manage these risks. In relation to restrictive practices, the care plans submitted for two consumers noted they are subject to chemical restraint, however, assessment and planning documentation does not reference the use or review of chemical restraint and only lists environmental restraint. In coming to my finding, I have considered two consumers were receiving regular psychotropic medication for behavioural and psychological symptoms of dementia and were not identified as being subject to a restrictive practice. Staff were unable to state if consumers were subject to chemical restraint and clinical staff could not explain the process of assessing consumers on psychotropic medications. No evidence was provided to demonstrate informed consent was provided for the use of chemical restraint or if assessments were undertaken to determine if the psychotropic medication was used as a restrictive practice. For another consumer, assessment and planning did not identify the risk of the consumer who was prone to leave the service unaccompanied and has three occasions where their whereabouts were unknown.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not 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. | Not Compliant |

Findings

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following an assessment contact undertaken from 5 March 2024 to 6 March 2024 where it was found an effective risk management system, specifically in relation to consumers taking risks of choice, managing high impact or high prevalence risk and incident management, were not demonstrated. The service implemented improvement actions, including training for all staff on care planning, risk assessments, the incident management system, implementation of new forms for capturing dignity of risk, regular internal audits and monitoring of reported incidents to ensure the clinical team are following correct processes.

At the assessment contact undertaken on 23 July 2024, staff and management confirmed training has been provided to assist in the identification and management of high impact high prevalent risks to support consumers to engage in activities where risks are identified and prevent abuse and neglect of consumers. However, the assessment team recommended requirement (3)(d) not met as effective governance systems to ensure the incident management system is effective were not demonstrated.

Actions in the provider’s response included, but were not limited to, updating the current incident management form to support a comprehensive post incident assessment to focus on the cause of the incident and update the incident register, and associated reporting on trends to better inform continuous improvement.

I acknowledge the provider’s response and the actions planned. In coming to my finding, I have considered the intent of this requirement which states incidents should be identified and the incident data used to identify trends, drive continuous improvement to improve the quality of the care and services, and prevent similar incidents from occurring. The incident report did not have investigations documented for the 24 falls that occurred in May 2024 to identify causal factors, only immediate actions taken following the fall were noted. Falls also increased from 24 in May 2024 to 34 in June 2024 but no analysis was undertaken to determine the root cause or target improvements to determine if any of these falls were preventable. Four consumers also had friction injuries and actions taken to treat these were documented, however, no information was documented on what the cause of these injuries were to potentially prevent other consumers sustaining the same type of injuries in the future. I note consumers and representatives interviewed were satisfied with the care consumers receive, and the actions taken by the service when incidents occur. I also note the improvements made to ensure incidents are consistently investigated and strategies to prevent recurrence are identified and documented, however, no evidence was provided to demonstrate the incident management system, and governance processes, consistently capture casual factors to drive continuous improvement to improve the quality of the care and services and prevent similar incidents from occurring. I consider time is required to embed and monitor the improvements to determine their effectiveness.

**Requirement (3)(e)**

Requirement (3)(e) was found non-compliant following an assessment contact undertaken from 5 March 2024 to 6 March 2024 where it was found effective risk management or clinical governance systems, specifically in supporting consumers to take risks to live their best life, the management of incidents, and minimising the use of restraint, were not demonstrated. The service implemented improvement actions, including education on restrictive practices, development of a restrictive practice register and review of all consumers to ensure restrictive practices are identified and all appropriate consents and authorisations are in place

At the assessment contact undertaken on 23 July 2024, documents showed the service demonstrates open disclosure when negative events occur and addressed some specific issues during the last assessment contact, however, the assessment team recommended requirement (3)(e) not met as an effective clinical governance framework for minimising use of restrictive practices, clinical care planning, and risk assessment processes undertaken by staff were not demonstrated.

Actions in the provider’s response included, but were not limited to, the review of the organisation’s clinical governance framework and consideration of implementing weekly leadership meetings to review any outstanding consumer assessments.

I acknowledge the provider’s response and the actions planned. In coming to my finding, I have considered that whilst improvements have been made to the clinical governance framework, staff said that medications prescribed by the older adult mental health team are never considered to be a restrictive practice, and there was no evidence to demonstrate a process is in place to identify when a consumer is subject to chemical restraint. A governance framework should be in place to determine if consumers prescribed psychotropic medication are subject to chemical restraint and have the necessary assessments and consent processes undertaken. The clinical governance framework did not support staff to have effective oversight of incidents and trends and accountabilities for ensuring the overall effectiveness of care were unclear. The implementation of an assessment checklist was not seen to have had any accompanying governance processes to support its effective use, resulting in some consumers not having risks associated with their care identified and mitigated.

For the reasons detailed above, I find requirements (3)(d) and (3)(e) in Standard 8 Organisational governance non-compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)