Performance

Report

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| Name: | Hawthorn Village |
| Commission ID: | 8026 |
| Address: | 23A Wells Parade, BLACKMANS BAY, Tasmania, 7052 |
| Activity type: | Site Audit |
| Activity date: | 20 May 2024 to 22 May 2024 |
| Performance report date: | 4 July 2024 |
| Service included in this assessment: | Provider: 158 Christian Homes Tasmania Inc  Service: 4999 Hawthorn 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 Hawthorn Village (**the service**) has been prepared by Katherine Richards, 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; and
* the Approved Provider’s response submitted on 20 June 2024.

# Assessment summary

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

* **Requirement 2(3)(a)** – The service must ensure 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, particularly in relation to restrictive practices.

# 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 assessed as Compliant as 6 of the 6 Requirements have been found Compliant, as:

Consumers confirmed they were treated with dignity and respect, and staff valued their identity, culture and diversity. Staff demonstrated familiarity with consumers’ identity and preferences, and described how they treated consumers with dignity and respect. A diversity and inclusion procedure guided staff practice to ensure consumers’ identity, culture and diversity was valued.

Consumers reported staff were aware of their cultural preferences and they were supported to celebrate days of cultural significance. Care planning documentation reflected consumers’ cultural backgrounds, needs and preferences. Staff identified consumers’ unique cultural needs, and described how the consumer’s cultural information was identified through assessment and planning processes.

Consumers advised they were supported to make choices regarding the delivery of their care, including about the people involved, and to maintain relationships of their choice. Management confirmed they gathered information on Power of Attorney arrangements for decision making upon consumer’s initial entry to the service and recorded it within care planning documentation. Care planning documentation captured consumers’ care delivery choices and outlined the supports in place to maintain personal relationships.

Staff demonstrated an understanding of the activities which contained an element of risk that consumers chose to engage with, and advised they informed consumers of the potential risks, and included consumers in the development of harm minimisation strategies. Care planning documentation demonstrated risks were identified by the use of assessments and included strategies in place to promote consumer safety.

Consumers confirmed they were provided with current information to enable them to exercise choice, and make decisions regarding their care and services. Staff described how they adapted their communication style to ensure information was effectively communicated to consumers living with cognitive and sensory impairments, in alignment with their communication needs and preferences. Noticeboards were observed throughout the service which displayed information regarding upcoming activities and menu options.

Consumers advised staff were respectful of their privacy preferences, and their personal information was kept confidential. Staff were familiar with consumers’ privacy preferences and ensured they requested consumers’ consent prior to delivering care. Staff were observed to knock on consumers’ doors, introducing themselves, and awaiting their consent prior to entry. Computers containing confidential information were kept password protected when not in use.

# 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 |
| 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. | Compliant |

Findings

This Quality Standard is assessed as Non-Compliant as 1 of the 5 Requirements have been found Non-Compliant, as:

The Assessment Team recommended Requirement 2(3)(a) was not met, as they considered the organisation did not demonstrate the assessment and planning process identified the risks to consumers’ health and well-being, specifically in relation to the identification and assessment of potential environmental restrictive practices.

The Assessment Team observed several consumers wearing a wandering bracelet which automatically triggered the front doors to lock when they were in proximity. The bracelet alerted staff to consumers being in proximity of the front door, and management advised on average it would take staff 2 minutes to redirect the consumer before resetting the door mechanism. The locking of the doors by the wandering bracelet also potentially prevented other consumers from freely entering and exiting the service until the locks were reset. These consumers did not have documented risk assessments in place should a wandering bracelet trigger the doors locking and restrict their free access and movement. Management did not consider the wandering bracelets to constitute an environmental restrictive practice as the bracelets were in place to ensure the safety of consumers.

Furthermore, the Assessment Team observed the service had not assessed the cognitive and physical abilities of consumers to press a button to exit the service and to use an intercom when returning to the service, and consequently, consumers were further potentially subject to environmental restrictive practices. Consumers mostly indicated they could enter and exit the service independently or with staff assistance, however a consumer advised when returning to the service in the evening they sometimes waited up to 15 minutes for staff to respond and open the door. Management advised staff practice was to observe who was at the door, and they could remotely disengage the front door through the Digital Enhanced Cordless Telecommunications (DECT) system to permit a consumer entrance back into the service. In response to these observations of the locked doors and wandering bracelets, management coordinated assessments for all consumers to assess whether they could leave the service independently and their ability to release the doors and exit safely. Following this, management advised an additional 26 consumers were subject to environmental restraints.

Staff did not demonstrate a consistent understanding of the required assessments for environmental restrictive practices, and there was limited information contained within policies and procedures related to environmental restrictive practices to guide staff practice, this is further considered under Requirement 8(3)(e).

The Approved Provider’s response outlined the following information in response to the findings outlined above:

* The Assessment Team’s findings regarding the 26 consumers that were later considered to be subject to environmental restrictive practices was misleading, as management and the Assessment Team did not come to an agreed upon viewpoint of which consumers were subject to potential environmental restrictive practices. As a result, the Approved Provider contends that only 5 of the 26 initially advised consumers are subject to environmental restrictive practices, and this is due to their use of a wandering bracelet. The Approved Provider states the remaining 21 consumers were separated into two cohorts, the first of which were consumers that were not safe to exit the service unaccompanied, and the second cohort being consumers who were unable to mobilise without a wheelchair beyond their room. Consumers in both cohorts were not seeking to exit the service, nor were they denied exiting of the service, as staff could assist. The Approved Provider asserts these consumers were not environmentally restrained as the absence of consumers being denied exit from the service negates the presence of environmental restrictive practices.
* In response to the 5 consumers that wore a wandering bracelet, all consumers had a Behaviour Support Plan (BSP) in place which highlighted their associated risks and included risk mitigation strategies. The Approved Provider advised the consumer, their representative and Medical Officer were consulted and informed of the current strategies utilised and the ongoing concerns associated with the exit-seeking behaviour, and it was agreed upon to implement the bracelets to promote the consumer’s safety. The Approved Provider acknowledged the restrictive practice authorisation form had not been until during the Site Audit.
* The front entrance into the service is unlocked during the day, and locked during the evening, with entrance permitted through us of the intercom which activities the DECT system. The Approved provider advised the Registered Nurse will speak to the consumer via the DECT system to confirm their identity and remotely open the door, and reiterates the consumer does not need to wait for the staff member to travel to the front door. The Approved Provider considers the practice of locking the front door in the evening consistent with ordinary community standards and not an environmental restrictive practice.

I have considered the information provided by the Assessment Team and the Approved Provider, inclusive of their immediate actions to organise and complete assessments. I acknowledge the locking of the front door after-hours may be in alignment with community standards and utilised to enhance the security of consumers, staff and the service environment. However, for the cohort of consumers described by the Approved Provider and determined not to be safe to exit the service unaccompanied, there is limited information presented which outlines effective assessments have occurred which evidences their safety risks, and determines their cognitive and physical abilities to use the button to exit the service and to use the intercom during after-hours to return to the service. Additionally, there is limited information for assessment of the capacity of consumers to understand whether access to the external environment can be facilitated by staff at any time without condition. Although BSPs were in place for consumers who wore a wandering bracelet, these consumers were not identified to be subject to environmental restrictive practices prior to the Site Audit, and documentation outlining the regular review and monitoring of their restraint and the trial of alternative options in alignment with environmental restrictive practice regulatory requirements was not evidenced to be completed. I do not consider the service demonstrated that assessment and planning processes were used to identify all consumers who were potentially subject to restrictive practices. Therefore, I find the service is non-compliant with Requirement 2(3)(a).

Care planning documentation reflected consumers’ current needs, goals and preferences, inclusive of their end of life goals. Consumers confirmed they were consulted on their needs and preferences, and had opportunity to discuss advance care planning and their end of life wishes. Policies and procedures guided staff practice in the assessment and planning of advance care directives.

Consumers and representatives confirmed their involvement in the assessment, planning and review of consumers’ care and services. Care planning documentation evidenced regular involvement from medical officers, allied health professionals and specialist providers in the development and assessment of consumers’ care. Staff advised they ensured consumers and their representatives were involved in assessment and planning of consumer care.

Consumers reported assessment outcomes were regularly communicated to them, and they were offered a copy of their care plan. Staff confirmed a copy of the care and service plan was offered to consumers and representatives during reviews or following changes in the consumer’s condition, and assessment outcomes were accessible through the electronic care management system.

Care planning documentation evidenced consumer care directives were assessed following changes in the consumer’s condition and additional strategies to promote the safety of consumers were implemented. Staff advised care and service plans were reviewed every 4 months or when the consumer’s circumstances changed, and they provided oversight of the review process to ensure care plans were evaluated for effectiveness.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been found Compliant, as:

Consumers and representatives advised consumers received safe and effective care which was tailored to the consumer’s needs. Staff demonstrated an understanding of consumers’ personal and clinical care needs, and the strategies in place to ensure their health and well-being was optimised. Care planning documentation mostly evidenced consumers received care in alignment with best practice and the implementation of personalised management strategies, however some consumers were not assessed for the potential for environmental restraint, see Requirement 2(3)(a) for further information.

Consumers confirmed the high impact risks to their well-being were effectively managed, and appropriate risk mitigation strategies were in place. Staff were familiar with consumers’ care directives to ensure risks were appropriately monitored and managed. Care planning documentation identified the strategies in place to mitigate risks to consumers.

Staff described how they would provide support to consumers during end of life care, including by ensuring their comfort was maximised and providing pain management. Care planning documentation for a consumer receiving palliative care evidenced the delivery of their care was in alignment with their end of life needs, goals and preferences. Management advised palliative care specialists were able to review consumers and provide support during end of life care.

Representatives advised deterioration in the consumer’s health was recognised and responded to in a timely manner. Staff described the signs and symptoms they would look for which may indicate deterioration in the consumer’s condition, and advised their practice was guided by policies, procedures and workflows. Care planning documentation evidenced deterioration in the consumer’s health, mobility and alertness were recognised, and their care directives were updated.

Staff advised information regarding the consumer’s condition and care needs were communicated during handovers, meetings and conversations, and was documented within the electronic care management system which was accessible staff and external providers of care. Consumers were confident their information was collected and shared appropriately. Care planning documentation, including progress notes and wound charts, evidenced information regarding consumers’ condition, needs and preferences were documented and regularly updated.

Staff demonstrated an understanding of the referral process to allied health professionals, and management advised they maintained oversight and reviewed clinical data to recommend further referrals when required. Care planning documentation evidenced referrals to allied health professionals and specialist providers were made in response to changes to the consumer’s condition.

Consumers and representatives confirmed COVID-19 outbreaks were effectively managed and they were provided regular communication regarding updates to protocols and testing requirements. Staff described their roles and responsibilities in relation minimise the transmission of infections, and advised they would await pathology results prior to the commencement of antibiotics. Staff were observed to wear appropriate personal protective equipment and practicing hand hygiene, and to sanitise equipment after use.

# 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 assessed as Compliant as 7 of the 7 Requirements have been found Compliant, as:

Consumers advised they were provided with services and supports which promoted their independence, well-being and quality of life. Staff were familiar with the needs and preferences of consumers, and described how they supported consumers to engage in activities which optimised their quality of life.

Consumers confirmed they were supported to emotional and spiritual supports when they were feeling low. Care planning documentation identified the supports required by consumers to maintain their emotional, spiritual and psychological well-being. A volunteer advised they attended the service twice weekly to support the chaplain with providing emotional support to consumers.

Consumers advised they were supported to participate in activities within the internal and external community, and to maintain social relationships. Staff described how they supported and encouraged consumers to socialise with each other during meals, coffee clubs and group activities. Staff advised the various interests and needs of consumers were considered when creating the lifestyle activities program.

Staff demonstrated an understanding of consumers’ condition, needs and preferences, and advised information was communicated during daily handovers and regular meetings. Consumers reported their needs and preferences were effectively communicated between staff. Care planning documentation identified the needs and preferences of consumers, and contained detailed information to support the delivery of safe and effective care.

Staff provided examples of referrals to external services and supports for consumers, such as volunteers and visitor programs to enhance consumers’ emotional and well-being support. Consumers confirmed they were referrals to volunteers in an appropriate and timely manner.

Consumers expressed satisfaction with the quality, quantity and variety of meals provided to them. Care planning documentation evidenced consumers’ current dietary needs and preferences were captured, and this information was accessible to kitchen staff. The kitchen was observed to be clean, and food safety records were up to do date.

Consumers confirmed their equipment was safe, clean and well maintained. Maintenance documentation evidenced identified issues with equipment was promptly resolved. Staff outlined their responsibilities to ensure equipment was clean and well maintained.

# 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 assessed as Compliant as 3 of the 3 Requirements have been found Compliant, as:

Consumers and representatives described the service environment was warm, welcoming and easy to understand. Staff advised they encouraged consumers to personalise their rooms with their artwork, furniture and photos to promote their sense of belonging. The service environment displayed photographs of special occasions and events held within the service, and consumers’ rooms were observed to be personalised.

Consumers and representatives confirmed the service environment was clean, well maintained and comfortable, and consumers mostly expressed they could move freely through indoor and outdoor areas. Cleaning records evidenced the regular cleaning of consumers’ rooms and communal areas. Staff identified the processes to report hazards within the service environment through an electronic system and directly with maintenance staff.

Consumers reported their equipment, furniture and fittings were safe, clean, and well maintained, and any issues were promptly addressed. Preventative maintenance documentation evidenced the regular testing and servicing of the fire safety system and other equipment. Staff advised all requests for repairs were monitored electronically and the urgency of the repair was assessed.

# 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

This Quality Standard is assessed as Compliant as 4 of the 4 Requirements have been found Compliant, as:

Consumers and representatives reported they were encouraged and supported to provide their feedback or make a complaint. Management advised consumers and representatives were supported to provide their complaints through the completion of feedback forms and emails, and they maintained an ‘open-door policy’, whereby consumers could speak directly to staff or management regarding their feedback and complaints. The consumer handbook provided consumers with information regarding the feedback, compliments and complaints processes.

Consumers and representatives were aware they could access external advocacy services to assist them to raise a complaint, including through the Commission. Staff demonstrated an understanding of the advocacy services available to consumers, and described how they would access translation services on behalf of consumers. Information regarding translation and advocacy services was observed to be displayed throughout the service.

Consumers and representatives confirmed their complaints were responded to appropriately, and staff acknowledged their complaints and provided an apology. The complaints register evidenced open disclosure practices were applied when responding to complaints and feedback. Staff described the open disclosure process, including providing an acknowledgment and apology in response to complaints, and resolving the complaint in consultation with consumers and their representatives.

Consumers and representatives reported their feedback and complaints have led to care and service improvements. Management advised feedback and complaints were reviewed during monthly meetings to identify trends and inform improvement initiatives. The continuous improvement plan detailed records of complaints and included the improvements actions arising from the resolution of the complaint.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been found Compliant, as:

Consumers and representatives confirmed there were enough staff to meet consumers’ care needs in a timely manner. Staff reported there were sufficient staffing levels to complete their duties, and they felt supported. Management advised the monthly staffing roster was created in consideration with regulatory care minute requirements and the care needs of consumers, and an additional staff member was rostered on to mitigate the impact of unplanned leave.

Consumers and representatives expressed staff were kind, caring and respectful when providing care to consumers. Management advised staff received training on dignity and respect and the organisation’s Code of Conduct. Staff were observed to respectfully interact with consumers by using their preferred names, engaging them in various conversations and maintaining their privacy.

Consumers and representatives confirmed staff were competent and capable to perform their roles. Position descriptions outlined the necessary qualifications, registrations, knowledge and skills required for each role, and management confirmed they completed police checks to further ensure the suitability of staff. Management stated new staff members must complete an orientation process, engage in buddy shifts and complete their mandatory training prior to commencing independent practice.

Staff confirmed they received training during orientation and on an ongoing basis on various competencies including infection control, the Quality Standards and incident management, however staff did not demonstrate a thorough understanding of environmental restrictive practices. Training records evidenced all staff had either completed, or were scheduled to complete their annual mandatory training for the current calendar year. Management advised further training would be provided to staff if there were knowledge gaps identified through to trends and audits.

Management advised staff performance was monitored by performance appraisals occurring after 6 months of employment for probationary staff and on an annual basis thereafter, and described how they addressed underperformance. Management stated they further monitored and evaluated the performance of staff through meetings, observations and the analysis of feedback. Staff demonstrated an understanding of the performance appraisal process and confirmed they were supported to request additional training if required.

# 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. | 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. | Compliant |

Findings

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been found Compliant, as:

The Assessment Team recommended Requirement 8(3)(e) was not met, as they considered the organisation did not demonstrate the clinical governance framework was effective in relation to the identification and minimisation of environmental restrictive practices. They reported the clinical governance framework and associated policies did not contain clear definitions and procedures for environmental restrictive practices to guide staff practice, and consequently staff did not demonstrate a consistent understanding of the required assessments and regulatory requirements for its appropriate use. Policies and procedures for chemical, mechanical and physical restrictive practices, and seclusion were appropriately defined, and detailed the regulatory requirements for the effective and appropriate use of these restraints. However, the organisation’s clinical governance policy defined environmental restraint as ‘the denial of free access to all parts of the resident’s environment, including items or activities’, and was insufficiently detailed to guide staff practice.

The Approved Provider’s response acknowledged policies, procedures and staff knowledge regarding environmental restrictive practices could be more robust. They advised all restrictive practice documentation is under review to ensure the principles and processes of all forms are comprehensively addressed and communicated to staff. Evidence of meeting minutes from a Quality Care Advisory Body dated 17 June 2024 was provided, and detailed their acknowledgement of the potential environmental restraint issues raised during the Site Audit and their prospective actions to address the identified issues.

I have considered the information provided by the Assessment Team and the Approved Provider. Whilst there were identified discrepancies in the organisation’s clinical governance framework in relation to environmental restrictive practices, the Approved Provider is implementing improvements to enhance their policies, procedures and staff guidance. The Approved Provider is encouraged to review environmental restrictive practice information and guidance to ensure the accuracy of their definitions, considering matters which may restrict a consumer’s free movement and access rather than only ensuring access is not denied, as is currently described by organisational policy. Effective clinical governance systems were demonstrated in relation to all other types of restrictive practices, the use of open disclosure and antimicrobial stewardship practices. Therefore, I find the service is compliant with Requirement 8(3)(e).

Consumers and representatives advised the service was well run and confirmed they were engaged in the development of care and services through consumer meetings and the Consumer Advisory Body. Management advised consumers and representatives were actively engaged in the development of care and services through various meetings, feedback processes and surveys. Consumer meeting minutes and the complaints register evidenced consumers were encouraged to provide their feedback.

Management advised they regularly met with the governing body and provided them with reports clinical indicators, operational updates and audit results to ensure their effective oversight. The governing body consisted of Board members from a variety of clinical and non-clinical backgrounds, and management stated the governing body ensured quality assurance measures were in place and promoted diversity and inclusivity.

Organisation wide governance systems were informed through a framework with regular monitoring and reviewing of relevant data to ensure effective outcomes. Staff reported they could access the information required to perform their roles through the intranet, emails and meetings. The continuous improvement plan was reviewed on an ongoing basis by management, with improvement initiatives evaluated for effectiveness. Management outlined the governing body’s oversight of the budget approval process, and advised they engaged in monthly financial meetings. A range of policies and procedures were in place to guide the governance of the workforce, and outlined the expectations, requirements and responsibilities for staff. Feedback and complaints were electronically documented, and the governing body maintained oversight of complaint trends.

Effective risk management systems and practices, including policies and procedures were in place to identify and manage consumers’ high impact or high prevalence risks. Staff demonstrated an understanding of their responsibilities to escalate instances of elder abuse, neglect and other incidents through the incident management and reporting process. Management described how they supported consumers to live their best life through the identification, assessment and discussion of risks and mitigation strategies in consultation with consumers and their representatives. Management maintained oversight of the incident management system, with electronic alerts to prompt key managers to complete specific tasks if required.

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