Performance

Report

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| Name of service: | Performance report date: |
| Hill View House - Merrimac | 11 October 2022 |
| Commission ID: | Activity type: |
| 5503 | Site audit |
| Approved provider: | Activity date: |
| Hill View House Pty Ltd | 2 August 2022 to 4 August 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 Hill View House - Merrimac (**the service**) has been considered by Dee Kemsley, 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 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 Assessment Team’s report received 1 September 2022
* other information and intelligence held by the Commission in relation to the service.

# 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 | **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 | **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.

* Requirement 2(3)(a)**:** The approved provider ensures assessment and planning, considers and addresses risks relating to consumers subjected to restrictive practices.
* Requirement 8(3)(c): The approved ensures it has effective organisation wide governance systems relating to regulatory compliance.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| 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

Consumers said the service supported them to make informed choices to live the life of their choosing, which was further evidenced through care planning documentation and staff feedback. Consumers and representatives advised consumers were treated with dignity and their identity, culture, and diversity was supported and respected. Staff explained how they ensured care and services were delivered in a culturally safe manner, such as organising volunteers from different cultural backgrounds and hosting a multi-cultural week.

Consumers and representatives reported and care planning documentation demonstrated, consumers were supported to make decisions about their care, how it should be delivered and who should be involved in their care. Staff were knowledgeable of consumers’ preferences and choices, and described ways they supported consumers to communicate their decisions and maintain relationships of their choice.

Consumers and representatives considered consumers were supported to live their best life, and undertake risk-taking activities if this was their choice. Care plans showed risks were considered through a collaborative, multidisciplinary approach, with risk assessments completed for identified consumers

Consumers and representatives said information was provided to them in a timely and easy to understand manner, enabling them to make decisions. Information was provided to consumers through meetings, noticeboards, newsletters, blackboards and other published materials. Staff advised how they supported consumers with communication barriers by tailoring information based on individual needs.

Consumers said their personal privacy was respected by staff, and staff were observed knocking on consumers’ doors before entering. Staff described ways they maintained the privacy and confidentiality of consumers’ personal information, including the use of password protected electronic records and secured storing consumers’ personal information.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

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.

The site audit report identified that while the service evidenced how some consumer risk identification, assessment and mitigation occurred, risks associated with the provision of care for consumers with changing behaviours were not consistently identified, assessed or addressed as the service did not always recognise when management strategies implemented were restrictive practices. Some consumers’ behaviour support plans were available; however, they were not completed to inform care needed in relation to restrictive practices being applied, staff were unfamiliar with consumers’ behavioural support plans and were not accessing these plans to guide staff practice.

In relation to chemical restraint:

The service’s psychotropic register reflected 14 consumers prescribed antipsychotic medication with a listed indication of agitation. As the service did not consider the medication to constitute the restrictive practice of chemical restraint, the service was not able to demonstrate these consumers had been appropriately assessed and consulted as is legislatively required, and behaviour support plans had not been appropriately completed.

The approved provider in its written response to the Site Audit report’s findings said they had considered agitation was an acceptable diagnosis for the use of antipsychotic medication, and their reasoning why the medication had not been deemed chemical restraint. However, I have considered that as from 1 July 2021 approved providers had updated and specific responsibilities under the *Aged Care Act 1997* (the Aged Care Act) and the *Quality of Care Principles* (the Principles) relating to the use of any restrictive practice. It is reasonable to expect providers familiarise themselves with any amended legislative requirements in the Aged Care Act and Principles; I have considered this aspect further under Requirement 8(3)(c).

These Principles require providers to satisfy a number of conditions before and during the use of a restrictive practice and includes responsibilities relating to risk minimisation; as well as assessment, consent, documentation, monitoring and review responsibilities. While chemical restraint does not include medication prescribed to treat a diagnosed mental disorder, physical illness physical condition, or end of life care of the consumer, chemical restraint is the practice or intervention that involves the use of medication for the primary purpose of influencing a consumer’s behaviour; this includes influencing, moderating or controlling their behaviour.

For one named consumer receiving antipsychotic medications for agitation that is administered both regularly and ‘as required’ (PRN), clinical records documented the consumer had been administered one medication on a PRN basis twice for behaviours including agitation, and for not sleeping, wandering, and intruding on others. The service had not conducted an assessment in relation to the use of the antipsychotic medications for the consumer and no consent was completed. The consumer’s representative said while they were aware of the medications to manage the consumer’s behaviours no discussion had been undertaken by the service relating to the chemical restraint, and they would want to be informed of the potential risks associated with the consumer being subjected to a chemically restrictive practice.

In its response the approved provider confirmed the consumer’s chemical restraint authorisation had been attended on 4 August 2022, the last day of the site audit, and provided documentation to demonstrate assessment had been completed related to the consumer’s risk activities and strategies. The provider said and supplied documentation to support, the consumer had been receiving the medication prior to entry to the service, and regular consultation by the medical officer and geriatrician to review the consumer’s medication and wellbeing had occurred post entry.

However, I have considered that provider responsibilities under the Principles do not change when a consumer is new or enters a service with one or more restrictive practices already in place as part of their care, and the Aged Care Quality and Safety Commission (the Commission) developed a fact sheet to help providers understand their responsibilities regarding the management of new consumers who require restrictive practices or have started them before entering the service (January 2022), which is available to approved providers on the Commission’s website. On reviewing the documentation supplied by the provider, including the consumer’s hospital discharge records and medical officer and geriatrician reviews; I noted recorded reasons for reviews and treatments were related to the consumer’s increasing behavioural symptoms of aggression with Alzheimer’s disease and the worsening behavioural and psychological symptoms of dementia.

The provider in its response has advised a review of all the consumers at the service charted antipsychotic medication has been undertaken to ensure an appropriate clinical indication for the use of medication; however, I note that no outcomes established or actions taken have been evidenced by the provider in its response.

In relation to mechanical restraint:

For the named consumer the site audit report identified at night staff put the consumer’s bed at its lowest level to prevent the consumer getting out and falling. The service had not considered the floor line bed a form of restrictive practice as it was identified as a falls management strategy; the service had not conducted an assessment in relation to the use of the low-line bed and no consent was completed. However, I have considered the Principles state mechanical restraint as the practice or intervention that involves the use of a devise to prevent, restrict or subdue a consumer’s movement for the primary purpose of influencing the consumer’s behaviour.

The approved provider in its response said a consultation with the consumer’s representatives has occurred, the risk of the low-line bed impacting on the consumer’s freedom to mobilise independently was discussed, and an authority (acceptance of risk form) has been signed for the mechanical restraint. The service further conducted an audit on 15 August 2022 to determine if other consumers provided with low-line beds have been appropriately assessed; no other consumers have been identified by the service as being mechanically restrained.

In relation to behaviour support plans and staff understanding:

The site audit report identified staff overall did not have a shared understanding of the term behaviour support plan; once defined staff were unable to explain how they would refer to or implement the plans in practice. While the behaviour support plan for the named consumer included behaviour influences, relationships and social behaviours, and description and management of individual behaviours; the plan did not reflect the restrictive practices the consumer was subject to and staff were unaware of the plan or how it might support staff to manage the consumer’s changing behaviours.

In its response the approved provider stated to support staff to identify restrictive practice more effectively and the responsibilities toward use of restraint use, a face to face toolbox education session was conducted on the 8 August 2022 with the registered staff, handouts of the service’s responsibility pertinent to restrictive practice were provided and a message was sent out to all staff with regards to outlining all 5 categories of restraint use: mechanical, chemical, environmental, physical and seclusion. Updates have been attended to the service’s restrictive practice policy (restraints), risk taking and high prevalence risk policies and procedures with new terminology to support staff knowledge and effective risk management. Updates have also been attended to the service’s restrictive practice management audit to further monitor the compliance with restrictive practice management at the service.

The provider said and supplied documentation to support, the service had completed behaviour support plans for a number of consumers; a plan for continuous improvement for completion of these plans commenced 18 January 2022, training for registered staff had also started, continues monthly for new staff and the service’s assessment schedule has been updated to include the behaviour support plans. For the named consumer their behaviour support plan has been attended to reflect the current management of their changed behaviours. However, I have considered that the Principles required providers to have behaviour support plans in place as from 1 September 2021, for consumers who require behaviour supports and who require the use of restrictive practices. The Principles further specify the matters to be set out in behaviour support plans, including if restrictive practice is used and if the need for ongoing use of restrictive practice is indicated. The Commission developed a fact sheet to help providers understand their responsibilities regarding behaviour support plans (September 2021), which is available on the Commission’s website.

I acknowledge the provider’s response, the additional information provided and the actions initiated in response to the site audit report’s findings. However, I find at the time of the site audit, risks associated with the provision of care for consumers with changing behaviours were not consistently identified, assessed or addressed as the service did not always recognise which management strategies implemented were restrictive practices. Behaviour support plans were not completed to inform care needed in relation to restrictive practices being applied, staff were unfamiliar with consumers’ behavioural support plans and staff were not accessing these plans to guide staff practice.

Therefore, I find Requirement 2(3)(a) is non-compliant.

I am satisfied the remaining 4 Requirements of Quality Standard 2 are compliant.

Consumers and representatives advised they were generally involved in the assessment and planning of consumers’ care and services. Consumers said, and care plans demonstrated consumers’ needs, goals, and preferences including end of life care were identified and supported by the service. Consumers were consulted by a multidisciplinary team of medical professionals and other providers of care and services to best support their needs. Care planning documentation demonstrated consumers and representatives were informed of the outcome of assessment and planning. Staff explained care plans were reviewed every 4 months or when there was a change to a consumer’s circumstance and care plans demonstrated care and services were regularly reviewed for effectiveness.

# Standard 3

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| Personal care and clinical care | | Compliant |
| 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

Consumers advised they received personal and clinical care which was safe and right for their needs. Overall, care planning documentation demonstrated consumers received individualised care that was safe, effective, and tailored to specific needs. However, care documentation did not consistently inform staff practices in response to consumers’ changing behaviours, as consumers’ subject to restrictive practices were not always identified and assessed and behaviour support plan were not routinely completed, implemented or referred to inform consumer’s care. I have considered this further under Requirement 2(3)(a).

Staff said they were supported to provide best practice clinical care through the service’s established clinical processes, education program, and guidance resources and policies made available by the service. Staff demonstrated knowledge of how high impact or high prevalence risks were managed relating to falls, weight loss, skin integrity, and pain. Consumer feedback, and care planning documentation, including ongoing assessments completed when a change was generally identified, demonstrated high prevalent risks were effectively managed.

Care planning documentation, including progress notes and monitoring charts evidenced staff provided effective and dignified care for palliative consumers; staff were supported to provide appropriate palliative care through established policy and procedures.

Staff described processes for responding to deterioration or changes to consumers’ condition, and initiating referrals to the medical officer, allied health professionals, other medical specialists and hospital services. Care plans confirmed changes to consumers’ conditions were identified, and responded to in a timely and appropriate manner.

Staff said and documentation showed, information about consumers’ condition, needs, and preferences was shared within the service and with other providers of care through meetings, handover notes, referrals, progress notes, and other notifications. Staff, including the infection prevention control lead, demonstrated knowledge of infection control practices relevant to their roles and described strategies to minimise the use of antibiotics.

# Standard 4

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| Services and supports for daily living | | Compliant |
| 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

Consumers said they received safe and effective services and supports for daily living, which was important for their health and well-being and enabled them to do the things they wanted to do. Staff were knowledgeable of consumers’ goals and preferences, which aligned with consumer feedback and care planning documentation.

Consumers and staff described ways consumers’ emotional, spiritual, and psychological well-being was supported, including facilitated church visits and interactions with cultural volunteers. Consumers advised the service supported them to participate in their community within and outside the service environment, maintain important relationships, and do things of interest to them. Staff explained ways they supported consumers to make and maintain social and personal relationships, such as facilitating family visits and phone calls to consumers’ friends and family members.

Staff reported information about consumers’ needs was communicated through verbal processes and documenting information in the service’s electronic records management system. Consumers and representatives confirmed information about consumers’ conditions and needs were effectively communicated with others responsible for care. Care plans evidenced appropriate referrals and collaboration with services to support consumers’ varying requirements and interests.

Consumers advised meals were of a suitable quality and quantity, and they were able to choose what their preferences were for the day. Surveys and consumer and staff feedback demonstrated consumers provided input into the development of the menu, the quality and types of food available at the service. Equipment supplied for activities for daily living was observed to be suitable, clean and well maintained. Maintaince documentation demonstrated regular cleaning and servicing of equipment was undertaken.

# Standard 5

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| Organisation’s service environment | | Compliant |
| 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

Consumers and representatives said the service environment felt like home; it was safe, comfortable, and easy to understand and navigate. Consumers advised and observations evidenced consumers were supported to personalise their rooms. The service environment was observed to have sufficient light with wide hallways, adequate directional signage, hand rails, and dementia enabling principles of design to optimise consumers’ independence, interaction and function.

Consumers reported and observations confirmed, the service environment was clean, well maintained and free from clutter, allowing consumers to move freely indoors and outdoors. Cleaning and maintenance staff described their schedules and processes to ensure the service environment remained safe, was clean and well maintained. Observations, cleaning and laundry documentation logs, and maintenance records supported staff feedback.

Consumers said and observations evidenced, the service’s furniture, fittings, and equipment was suitable for consumers’ varying needs, was kept clean and well maintained. Consumers were aware of how to notify staff if equipment wasn’t working and consumers had access to a call bell system when they required assistance from staff.

# Standard 6

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| Feedback and complaints | | Compliant |
| 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

Consumers and representatives said consumers were supported to provide feedback and complaints, and were kept informed of processes to ensure appropriate action was taken. Staff described how they supported consumers and representatives to provide feedback and complaints, and information was made available to consumers and representative of alternative support available including options to utilise advocates, language services, and external complaints resolution services.

While some consumers were not aware of advocacy services available, advocacy signage was observed to be displayed; feedback forms and collection boxes were accessible and located throughout the service. Consumers and representatives said, and the complaints register demonstrated complaints were addressed in a timely and appropriate manner, using an open disclosure process when thigs went wrong.

Management explained how feedback and complaints were analysed and monitored to improve the quality of care and services provided; recent improvements included enhanced food services. Staff advised improvement actions taken in response to feedback and complaints were evaluated in consultation with consumers and representatives at meetings and through surveys.

# Standard 7

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| Human resources | | Compliant |
| 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

Overall, consumers said they received care and services from staff who were knowledgeable, capable and caring. Some consumers and representatives advised the workforce was short staffed at times; however, the consumers’ needs were being met and there had been no negative impact on consumers’ health and well-being. Management reported short staffing was due to high attritions rates and an increase in emergent leave due to COVID. Management stated recruitment was ongoing; a number of new staff were observed attending orientation during the Site Audit, and vacant shifts were backfilled using existing staff and agency staff. The shift roster demonstrated a high percentage of shift vacancies were replaced and call bell reports evidenced most calls were responded to in under 5 minutes. Based on the totality of evidence, I am satisfied the service’s workforce is planned to enable the delivery and management of quality care and services.

Consumers said they were treated by staff in a kind and caring manner, with their identity, culture, and diversity respected. Staff demonstrated an in depth understanding of consumers’ needs and preferences, which aligned with consumer feedback and care planning documentation. Staff were observed to engage with consumers and their family members in a respectful and personable manner; staff encouraged consumers while they mobilised and referring to consumers by their preferred name.

Management informed staff were supported to be competent in their roles through various strategies including mandatory and non-mandatory training, probationary reviews, annual performance reviews, and partnering new staff with an experienced staff member. Staff advised how they were supported to undertaking training and said they could access additional training as needed, to deliver outcomes required by the Standards. While management explained all staff must meet minimum qualification and registration requirements for their role, including current criminal history checks; records demonstrated 4 staff did not have current criminal history checks. I have considered this further under Requirement 8(3)(c).

Management stated they monitored and reviewed staff performance through observation and feedback, competency assessments, and analysis of internal audit results and clinical data. The service had documented policies and procedures to guide the monitoring of staff performance and the performance management of staff when issues are identified. All interviewed staff confirmed they either had, or were scheduled in for a performance appraisal.

However, the service had identified staff annual mandatory medication competencies for 2021 and 2022 had not been completed, and staff performance appraisals were overdue. Management demonstrated a plan was being actioned whereby staff were being rostered to complete the medication competencies, and annual performance appraisals had been scheduled for 2022. There were no high-risk medication incidents reported, or evidence of impact on consumers. As the service evidenced it had effective monitoring systems that identified the overdue competencies and performance appraisals, an action plan was implemented to rectify these issues prior to the site audit, and there was low risk of impact to consumers; I have determined these gaps are not indicative of non-compliance.

# Standard 8

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| Organisational governance | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

Effective organisation wide governance systems relating to regulatory compliance

The service had functional governance systems in place for information management, continuous improvement, financial and workforce governance, and feedback and complaints. However, the site audit report identified deficiencies in the governance system relating to regulatory compliance as the service’s processes and policies deviated from legislative requirements relating to restrictive practices for consumers, and the service had not consistently ensured current criminal history checks of staff in keeping with regulatory requirements.

In relation to restrictive practices:

The site audit report identified risks associated with the provision of care for consumers with changing behaviours were not consistently identified, assessed or addressed as the service did not always recognise when management strategies implemented were restrictive practices. The service’s psychotropic register reflected 14 consumers prescribed antipsychotic medication with a listed indication of agitation. As the service did not consider the medication to constitute chemical restraint, the service was not able to demonstrate these consumers, including one named consumer, had been appropriately assessed, consulted and consent obtained in relation to restrictive practices applied, as is legislatively required. For the named consumer, the service had also not identified the use of low-line bed a form mechanical restraint, as it was identified as a falls management strategy. However, I have considered that as from 1 July 2021 approved providers had updated and specific responsibilities under the Aged Care Act and the Principles relating to the use of any restrictive practice. I have considered this further under Requirement 2(3)(a).

The Principles further required providers to have behaviour support plans in place as from 1 September 2021. While some consumers’ behaviour support plans were completed, they were not completed to include the care needed in relation to restrictive practices being applied nor did they specify the specific matters to be set out in behaviour support plans as is required by the Principals. Staff were unfamiliar with consumers’ behavioural support plans and were not accessing these plans to guide staff practice. I have considered this further under Requirement 2(3)(a).

In its written response to the site audit report findings the approved provider reported on education and resources provided to support staff to identify restrictive practice more effectively, and updates made to the service’s restrictive practice, risk taking and high prevalence risk policies and procedures, and to the service’s audits to further monitor the compliance with restrictive practice management at the service. For the named consumer, assessments, consent and their behaviour support plan has now been attended to reflect the current management of their changed behaviours.

In relation to current criminal history checks:

Four staff were identified as being on roster who did not have current criminal history checks completed. The service’s policy required all staff to have current criminal history check, and service processes included human resources notifying staff of pending expiry and the need to complete their individual checks. However, these processes had been ineffective in identifying, notifying and following up with the identified staff.

In its response the provider acknowledged the lapse in monitoring of valid criminal history checks, and said staff leave had impacted the schedule for follow-up check correspondence not being updated in a timely manner. The provider supplied evidence of the updated criminal history checks for two staff (June and September 2021), which had not been updated on the register, and supporting documentation for one existing hospitality staff member to demonstrate they had made an application for an updated check, had signed a statutory declaration and who worked supervised at all times. One staff member had their clearance check obtained on 4 August 2022, the last day of the site audit, before starting their next shift. The service has implemented succession planning to ensure generated monthly reports and alerts of soon to expire national coordinated history checks of the workforce, are also monitored and coordinated by additional administration personnel.

I acknowledge the provider’s response, the additional information provided and the actions initiated in response to the site audit report’s findings. However, I find at the time of the site audit the service did not demonstrate an understanding of, or compliance with, the legislated requirements under the Aged Care Act and the Principles relating to the use of restrictive practices that became effective 1 July 2021, nor with the legislated requirements relating to behaviour support plans in place from 1 September 2021. Risks associated with the provision of care for consumers subject to restrictive practices were not consistently identified, assessed, consented to or addressed and consumers’ behaviour support plans were not completed to inform care needed in relation to restrictive practices being applied.

Therefore, I find requirement 8(3)(c) is non-compliant.

I am satisfied the remaining 4 requirements of Quality Standard 8 are compliant.

Overall, consumers considered the service was well run and their input was used in the development and delivery of care and services. Staff explained and documentation demonstrated consumers were able to provide feedback about care and services through meetings, surveys and direct feedback to staff. The governing body promoted a culture of safe and inclusive quality and care services as was generally evidenced through established frameworks, policies and procedures, and from management, staff, and consumer feedback.

The service demonstrated effective risk management systems for the management of high impact risks associated with care, response to abuse and neglect, support for consumers to live their best life, and management and prevention of incidents.

The service’s documented clinical governance framework included policies relating to antimicrobial stewardship, minimising the use of restraint, and open disclosure. Staff demonstrated knowledge of ways to minimise risk of infections, antimicrobial stewardship, and open disclosure. However, deficiencies were identified in consumer assessment, monitoring and evaluation, to support and demonstrate the minimisation of the use of restrictive practices, and in particular chemical restraint. I have considered the findings further under Requirements 2(3)(a) and 8(3)(c).

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)