Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | J E Murray Home |
| Service address: | 16 Deerness Way ARMADALE WA 6112 |
| Commission ID: | 7062 |
| Approved provider: | Dale Cottages (Inc.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 19 June 2023 to 20 June 2023 |
| Performance report date: | 23 August 2023 |

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

**This performance report**

This performance report for J E Murray Home (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives and staff;
* the provider’s response to the Assessment Team’s report received 19 July 2023; and
* a Performance Report dated 16 November 2022 for a Site Audit undertaken from 19 September 2022 to 21 September 2022.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Non-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.

**Standard 1 requirement (3)(d)**

* Ensure consumers are supported to take risks and the consequences of these risks are discussed and agreed management strategies implemented in consultation with consumers and/or representatives; and
* Review processes, policies and procedures relating to supporting consumers to take risks to enable them to live the best life they can.

**Standard 2 requirement (3)(a)**

* Ensure consumer care plans are individualised, congruent with assessment information and reflective of consumers’ current and assessed needs and preferences.
* Ensure risks to consumers’ health and well-being are identified and appropriate management strategies developed and implemented to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, and guidelines in relation to assessment, care planning and review.

**Standard 3 requirement (3)(b)**

* Ensure staff have the skills and knowledge to identify, manage, monitor, and provide appropriate care relating to high impact or high prevalence risks, including pressure area care, swallowing, and choking.
* Ensure policies, procedures, and guidelines in relation to management of high impact or high prevalence risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, and guidelines in relation to management of high impact or high prevalence risks.

**Standard 7 requirement (3)(c)**

* Ensure staff competency, skills and knowledge are assessed, monitored and tested to ensure staff are competent to undertake their roles.

**Standard 8 requirement (3)(d)**

* Review the organisation’s risk management processes in relation to supporting consumers to live the best life they can.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as the one specific requirement assessed has been found non-compliant. The Assessment Team recommended requirement (3)(d) in Standard 1 Consumer dignity and choice not met.

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following a Site Audit undertaken in September 2022 as each consumer was not supported to take risks to enable them to live the best life they could. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, reviewed and updated the Informed risk form; conducted an audit of consumers supported to take risks and commenced informed risk discussions with consumers, representatives and the General practitioner; and created an Informed risk register.

At the Assessment Contact undertaken in June 2023, the Assessment Team were not satisfied that when consumers choose to take risks to live their best lives, the risks are identified and documented in a way that informs staff to support each consumer’s choice. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer A’s risk form did not document all tailored recommended strategies to guide staff with mitigating risk relating to swallowing issues, including specialist recommendations.
* Consumer B’s risk form documented an increased risk of aspiration and choking. Consumer B said they enjoy eating food items which were observed in their room. There was no information to guide staff with Consumer B’s preference of consuming foods not in line with specialist recommendations.
* Consumer C did not have a current and signed risk form that informed staff of the increase to their fluid restriction levels and staff sampled were not aware of the change in the fluid restriction. Inconsistent fluid levels were noted on the handover document, care plan and fluid chart.
* Consumer D did not have a risk form relating to consuming alcohol which they were observed to be provided with. While the care file indicates Consumer D requires mildly thick fluids, the beverage was not thickened prior to serving.
* Consumer E did not have a risk form relating to sitting outside of the service. Consumer E has tried to leave the service on several occasions
* Two of four consumers said they did not have an informed discussion about risks associated with their choice to remain independent.

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to do to ensure compliance against the Standards, and support residents to live their best lives. The response included Plans for continuous improvement relating to consumer risk taking outlining planned actions relating to the deficits identified.

I acknowledge the provider’s response. However, I find each consumer, specifically Consumers B, D and E, were not effectively supported to take risks safely. I acknowledge consumers highlighted are partaking in a range of activities which include an element of risk, in line with their wishes and preferences. However, I have considered a collaborative approach to the assessment process was not demonstrated to have been undertaken to help consumers understand related risks or to allow them to make decisions and choices relating to how these risks could be managed to assist them to undertake these activities safely. This was further supported by feedback from two consumers who stated they had not had an informed discussion about risks associated with their choice to remain independent.

In relation to Consumers A and C, the evidence presented is more aligned with assessment, planning and delivery of care rather than choice and decision-making as it relates to partaking in activities which include an element of risk. As such, I have considered this evidence in my finding for requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers and requirement (3)(b) in Standard 3 Personal care and clinical care.

I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(d) in Standard 1 Consumer dignity and choice non-compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as the specific requirement assessed has been found non-compliant. The Assessment Team recommended requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(a)**

Requirement (3)(a) was found non-compliant following a Site Audit undertaken in September 2022 as assessment and planning, including consideration of risks to consumers’ health and well-being, did not inform delivery of safe and effective care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, new assessment forms, a risk register and discussion of risks with staff.

At the Assessment Contact undertaken in June 2023, assessment, and planning, including consideration of risks to consumers’ health and well-being was found not to inform delivery of safe and effective care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer F was identified as having difficulty swallowing in June 2023. While the care file included an entry indicating the Registered nurse would review Consumer F’s swallowing ability at the next meal, this did not occur. The following day, Consumer F was coughing and was assessed as requiring thickened fluids. Consumer F was also offered a food item on both occasions which was not compatible with their diet.
  + Consumer F’s care file did not include guidance to staff on when to apply oxygen or acceptable oxygen saturation ranges.
* Consumer A’s assessment and care plan states food is to be cut up prior to serving. A Speech pathology assessment dated November 2022 outlined recommendations to minimise coughing episodes while consuming fluids, including supervision. Consumer A’s lunch was observed to be served in their room and care staff were not aware if Consumer A required supervision. Staff advised Consumer A generally eats meals alone in their room.
  + Consumer A had two consent forms, including one dated March 2023 which did not include the Speech pathologist’s recommendations. A form dated May 2022 included Consumer A’s preference to consume a food item, however, had not been updated since that time; it is not clear whether it was superseded by the March 2023 form. Neither form included discussions relating to potential consequences to Consumer A should they wish to eat consistencies other than those recommended by the Speech pathologist.
* Consumer B’s risk form included a food preference not recommended with their current diet or in line with Speech pathologist’s recommendations. Consumer B was observed to have food items in their room which were not in line with dietary guidelines and Consumer B had not been assessed as to the risk of eating these foods.
* Consumer D did not have a risk assessment for consumption of alcohol.
* Consumer E had not been assessed for risks relating to absconding from the service despite this occurring on three occasions. The representative said they have not had a discussion of risk with the service and was advised the service was ‘keeping a close watch’ on the consumer.
* Consumers F and G have had multiple falls with risk assessments updated in response, however, falls assessments have not been completed in line with the policy, with assessments for both consumers dated July 2022. Since this time, Consumer F has had a further six falls and Consumer G a further five.

In coming to my finding for this requirement, I have also considered information relating to Consumer C’s increased fluid restriction level highlighted in Standard 1 Consumer dignity and choice requirement (3)(d).

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to do to ensure compliance against the Standards, and support residents to live their best lives. The response included Plans for continuous improvement relating to implementation of new clinical management software; review of falls policies and procedures; and staff training. The provider’s response also included supporting documentation relating to Consumer F’s oxygen management.

I acknowledge the provider’s response. However, I find assessment and planning processes have not been consistently undertaken to enable risks to consumers’ health and well-being to be identified and appropriate management strategies implemented. For activities Consumers D and E choose to partake in, associated risks, which have the potential to increase risk of harm to consumers’ safety, health, and well-being, have not been considered or adequately addressed through assessment and planning processes. There was no documented evidence demonstrating risks related to Consumer D’s choice to consume alcohol, including not consuming it at the recommended consistency had been considered. For Consumer E, the risk of absconding had not been considered despite the consumer’s preference to sit outside of the service and history of absconding incidents. Consumer A’s consent forms did not include Speech pathologist recommendations to promote safe swallowing and staff sampled were unaware of the recommendations. Assessments related to Consumer B’s preference to consume food items not in line with Speech pathologist recommendations had not been completed at all. Furthermore, staff were found to not be completing falls assessments in line with service policy. As such, the evidence presented demonstrates care plans are not tailored to consumers’ specific needs nor do they inform how, for each consumer, care and services are to be safely delivered, with inconsistencies in assessment and planning having the potential to impact on the effective delivery of care and services.

In relation to observations of Consumer A during meal service, and Consumer F’s swallowing, the evidence presented is more aligned with provision of care. As such, I have considered this evidence in my finding for requirement (3)(b) in Standard 3.

In relation to Consumer F’s oxygen, supporting documentation included in the provider’s response demonstrates oxygen management was part of Consumer F’s care plan and oxygen saturations were being monitored.

I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

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

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the two specific requirements assessed has been found non-compliant. The Assessment Team recommended requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(a)**

Requirement (3)(a) was found non-compliant following a Site Audit undertaken in September 2022 as consumers were found to not receive best practice and tailored care, as chemical restraint was not used minimally and as a last resort. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, ensuring all consumers on chemical restraint have personalised Behaviour management plans and staff are aware of non-pharmacological strategies; provided education to staff; and reviewed related processes.

At the Assessment Contact undertaken in June 2023, the Assessment Team were not satisfied each consumer was receiving safe and effective personal and/or clinical care. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Staff have not implemented actions in line with Consumer H’s Diabetes management plan in response to blood glucose levels recorded out of range over the past two weeks.
* Consumer I’s representative was not satisfied with the personal care Consumer I receives. They stated they have found Consumer I on occasions with dirty nails and with strong body odour and was planning on raising issues related to poor oral hygiene.

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to do to ensure compliance against the Standards, and support residents to live their best lives. The response included Plans for continuous improvement outlining planned actions relating to diabetes management, including staff training; review of policies and procedures; undertaking an audit; and daily review of blood glucose levels.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. I have considered the evidence presented does not indicate systemic deficits relating to provision of safe and effective personal and/or clinical care as it relates to this requirement. While I acknowledge feedback provided by Consumer I’s representative, there was no indication that this was a longstanding issue or that the representative had raised their concerns with the service to allow them to investigate further. I have also placed weight on evidence in the Assessment Team’s report indicating that documentation sampled demonstrated personal care was provided daily to Consumer I. In relation to Consumer H, while I acknowledge the deficits identified by the Assessment Team, I have considered the provider’s response that includes actions to address the deficits identified which has persuaded me that the service generally has systems and processes to monitor consumers’ diabetes management.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care compliant.

**Requirement (3)(b)**

Requirement (3)(b) was found non-compliant following a Site Audit undertaken in September 2022 as high impact or high prevalence risks associated with consumers’ care, specifically wounds, pain, fluid restrictions and weight were not effectively managed. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including implementing meetings to discuss risk.

At the Assessment Contact undertaken in June 2023, risks associated with choking and aspiration and pressure injuries were found to not be effectively managed. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The representative was not satisfied Consumer H was receiving pressure area care in accordance with the care plan leading to further pressure injuries developing. Staff stated they attend to Consumer H’s pressure area care when they are in bed and Consumer H is not in the recliner chair for long enough periods to require this. The care plan states pressure area care is to occur every two to three hours. Consumer H was observed in the recliner chair for longer than two to three hours and did not receive pressure area care.
* Consumer H is at risk of choking due and has a risk form relating to consuming foods which contradict recommendations and management strategies. The strategies were not observed to be implemented.
* A meal was observed to be served to Consumer A which was not consistent with their dietary recommendations. On day one, Consumer A was unsupervised.
* In June 2023, Consumer F was identified as having difficulty swallowing. While the care file included an entry indicating the Registered nurse would review Consumer F’s swallowing ability at the next meal, this did not occur. The following day, Consumer F was coughing on fluids and was assessed as requiring thickened fluids. Consumer F was also offered a food item on both occasions which was not compatible with their diet.
* Consumer D was observed to be provided an alcoholic beverage. Consumer D is on mildly thick fluid; the beverage was not thickened prior to serving.

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to be done to ensure compliance against the Standards, and support residents to live their best lives. The response included Plans for continuous improvement relating to review of pressure injury management and nutrition and hydration policies and procedures; staff training; and audits.

I acknowledge the provider’s response. In coming to my finding, I have considered that this requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. Based on the Assessment Team’s report, I find this did not occur for the four consumers highlighted, specifically in relation to management of pressure area care and swallowing/choking. Pressure area management was observed to not be provided to Consumer H in line with their assessed needs. Documentation sampled indicates a pressure injury, which has now healed, had periods of deterioration over the two months preceding the Assessment Contact. Consumers A and D were observed being served meals and/or fluids which were not in line with their assessed needs and staff sampled were unaware of the requirement to supervise Consumer A during mealtime activities. In relation to Consumer F, food items were served on two consecutive mornings which were not in line with assessed needs. I have also considered prompt assessment of Consumer F’s swallowing did not occur following an episode of coughing. The consumer’s fluid consistency was not downgraded until a further coughing episode occurred the next morning.

I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as the one specific requirement assessed has been found non-compliant. The Assessment Team recommended requirement (3)(c) in Standard 7 Human resources not met.

**Requirement (3)(c)**

Requirement (3)(c) was found non-compliant following a Site Audit undertaken in September 2022 where it was found the workforce was not competent and the members of the workforce did not have the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, provided training to staff, and reviewed and updated policies, procedures and associated registers and forms.

At the Assessment Contact undertaken in June 2023, multiple examples of where staff did not demonstrate they were competent to perform their role or follow policies and procedures which impacted the delivery of care and services provided were identified. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Staff did not demonstrate knowledge of completing assessment and planning, including consideration of risks resulting in some consumers not being assessed in line with policies and procedures and associated care plans, documentation and forms not being up to date to guide staff with delivering care and services.
* Training was conducted with staff regarding the amended risk process, relevant documentation, and registers. Staff completing this process have not ensured all consumers are reviewed six monthly, information on risk forms is accurate to guide staff and mitigate risks or ensured the risk register is up to date in line with policy and procedure.
* While Consumers F and G had sustained multiple falls, falls assessments had not been completed in line with policy and procedure.
* Staff competence in the management of high impact or high prevalence risks associated with the care of consumers was not demonstrated.

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to do to ensure compliance against the Standards, and support residents to live their best lives. The response included Plans for continuous improvement relating to deficits highlighted in Standards 1, 2, 3 and 8, including providing training to staff related to the deficits.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the knowledge to effectively perform their roles. In coming to my finding, I have considered outcomes for consumers highlighted in Standards 1, 2 and 3 which indicate staff skills and knowledge are not adequate to ensure risks related to activities consumers choose to partake in are effectively identified and managed in consultation with consumers; appropriate assessment and planning, including in relation to risks is undertaken and high impact or high prevalence risks, specifically in relation to pressure area care and swallowing/choking are effectively managed. Assessment and planning had not been undertaken in line with the service’s policies and procedures resulting consumers’ care plans not being up to date to guide provision of care and services. While staff had received training in relation to new risk processes, these processes were found to not be completed in line with the new process.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | Non-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

The Quality Standard is assessed as non-compliant as one of the two specific requirements assessed has been found non-compliant. The Assessment Team recommended requirement (3)(d) not met and requirement (3)(e) met.

**Requirement (3)(d)**

Requirement (3)(d) was found non-compliant following a Site Audit undertaken in September 2022 as risk management systems and practices were not effective in managing high impact or high prevalence risks associated with consumers. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, updating existing risk forms, using a risk register, and discussing consumer risk as part of the clinical risk meeting agenda.

At the Assessment Contact undertaken in June 2023, the Assessment Team were not satisfied high impact or high prevalence risks were effectively managed, consumers were being supported to live the best life they can, or incidents were being effectively managed and prevented. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Evidence obtained from consumer profiles identified the governance system did not support delivery of care to Consumers G, F, A and B in relation to management of falls and choking risk.
* Consumers are supported to take informed risks based on their preferences to live the best life they can. Documentation confirmed a risk register is maintained and risk forms outline activities consumers wish to take, and strategies to minimise any associated risks.
  + The risk register did not reflect all consumers with an Informed risk. Five of seven consumers sampled did not have a current and signed Informed risk form in line with policy and procedure.
  + Management said, and the risk register noted, consumers are reviewed six monthly. Documentation for four consumers was dated October 2022, with no evidence of review.
  + The risk register did not include Consumer B’s risk of choking/aspiration as noted on the handover sheets to guide staff.
  + Two consumers felt they did not discuss risks associated with their choice to remain independent, despite progress notes for both consumers stating ‘risk reviewed and discussed with resident.’

The provider’s response acknowledged the Assessment Team’s recommendation stating they recognise and acknowledge there remains work to do to ensure compliance against the Standards, and support residents to live their best lives. While the response did not include a Plan for continuous improvement specifically relating to this requirement, Plans for continuous improvement provided for Standard 1 requirement (3)(d) included consideration of improvement actions encompassing systems and processes related to supporting consumers to live the best life they can.

I acknowledge the provider’s response. However, I find effective risk management systems and practices, specifically in relation to supporting consumers to live the best life they can were not demonstrated. In coming to my finding, I have considered staff have not consistently followed related policies and procedures. Risk registers were not reflective of all identified consumers and consumers had not been reviewed in line with the service’s process. I have also considered all risks relating to activities consumers choose to partake in had not been not identified or strategies to mitigate risks developed. As highlighted in Standard 1 requirement (3)(d) and Standard 2 requirement (3)(a), relevant factors, which have the potential to increase the risk of harm to consumers’ safety, health, and well-being, had not been considered through assessment processes or management strategies to reduce the risk of harm developed. Additionally, these processes not been undertaken in consultation with consumers to enable them to make an informed decision about their care and services. As such, I consider that this has not ensured the possibility of risks and the impact to consumers is reduced.

I do not consider the evidence presented demonstrates systemic deficits relating to risk management systems and practices related to management of high impact or high prevalence risks and management of incidents. I have considered deficits relating to swallowing/choking risks for individual consumers is aligned with assessment and planning and provision of care and deficits relating to falls are solely related to assessment and planning. As such, this evidence has been considered in my findings for Standard 2 requirement (3)(a) and Standard 3 requirement (3)(b). I have considered evidence highlighted in the Assessment Team’s report demonstrating high impact or high prevalence risk data is identified through clinical assessments and incident reviews and documentation sampled confirmed the data is analysed and discussed at monthly clinical meetings and reported to the Board

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

**Requirement (3)(e)**

Requirement (3)(e) was found non-compliant following a Site Audit undertaken in September 2022 as the organisation’s clinical governance framework was found to not be effective in minimising the use of restraint. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, facilitating a SIRS training model to staff as a refresher.

At the Assessment Contact undertaken in June 2023, a clinical governance framework, inclusive of antimicrobial stewardship, minimising use of restraint and open disclosure was demonstrated. An antimicrobial stewardship flowchart is available to guide staff and clearly outlines processes to prevent, manage and control infections and to monitor antimicrobial use. Training records demonstrated staff complete mandatory training on infection control and prevention, and staff interviewed explained everyday processes to prevent the spread of infection. Documentation relating to use of chemical restraint demonstrated effective implementation of new Behaviour support plan templates, and evidence of reduction and personalised strategies to assist with behaviours prior to administering medications. The open disclosure policy describes a process for when things go wrong, and staff sampled demonstrated an understanding of open disclosure. Monthly reports showed clinical data is trended at both a service and organisational level and used to identify opportunities for improvement.

# For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance compliant.

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