Performance

Report

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| Name of service: | Performance report date: |
| Juniper John Bryant | 13 July 2022 |
| Commission ID: | Activity type: |
| 7189 | Assessment Contact |
| Approved provider: | Activity date: |
| Uniting Church Homes | 15 June 2022 to 16 June 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 Juniper John Bryant (**the service**) has been considered by Peter Griscti, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

the Assessment Team’s report for the Assessment Contact, the Assessment Contact 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 to the Assessment Team’s report received 6 July 2022.

# Assessment summary

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| Standard 7 Human resources | Not applicable as not all requirements have been assessed |
| **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 8 Requirement (3)(e)**

Review clinical framework for effectiveness in recognising restrictive practices, including, but not limited to, chemical and environmental restraint.

Ensure organisational tools, systems and staff knowledge support use of psychotropic medication (where applicable) in a best-practice manner, including clearly identifying and linking the clinical diagnosis/es for specific medications when prescribed.

Ensure the clinical framework supports an individualised approach to assessment/reassessment of restrictive practices, including, but not limited to, when individual consumer condition or situation changes and in determining appropriate interventions or alternate strategies.

**Standard 7**

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| Human resources | | Not applicable |
| 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 |

## Findings

The service was found Non-compliant with Requirement **7(3)(a)** following a Site Audit conducted 21 September 2021 to 22 September 2021 where it was unable to demonstrate the workforce was planned to enable, and the number of deployed staff able to deliver consistent delivery and management of safe and quality care and services. This included insufficient numbers of staff to spend time assisting consumers during meals, address continence needs, provide adequate afternoon supervision and facilitate activities in the afternoon which resulted in isolation for some consumers.

At the Assessment Contact on 15 June 2022 to 16 June 2022, the Assessment Team found the service had made improvements in workforce planning and delivery, including increasing Occupational Therapist hours and activities offered to consumers throughout the day. Consumer and representative feedback indicated satisfaction with staffing numbers, in addition to the Assessment Team viewing positive feedback received by the service from families regarding the number of staff and care provided during a recent COVID-19 outbreak.

The service demonstrated it monitors and reviews call bell response times, with a recently completed evaluation demonstrating an improvement. Management were able to discuss how planned leave is managed and vacant shifts covered by staff from within the organisation.

In coming to my finding, I have considered that the service has implemented improvements relating to workforce planning and deployment of personnel to provide care, evidenced by the positive feedback received, staff and management feedback, and addressing issues raised through previous assessment.

Accordingly, I find the Approved Provider Compliant with this Requirement.

The Assessment Team did not assess all Requirements in Standard 7, therefore, a compliance finding at Standard-level is not applicable.

**Standard 8**

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| Organisational governance | | 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. | Non-compliant |

## Findings

The service was found Non-compliant with Requirement **8(3)(e)** following a Site Audit conducted 21 September 2021 to 22 September 2021 where they were unable to demonstrate an effective clinical governance framework to support minimisation of restrictive practices, aligned to legislative requirements.

At the Assessment Contact on 15 June 2022 to 16 June 2022, the Assessment Team found the service had implemented improvements, including, but not limited to:

Updated organisational documentation relating to restrictive practices, distributed to staff.

Face-to-face training for all staff relating to restrictive practices and restraint minimisation.

Revision of behaviour support plans for consumers identified at the previous assessment, with subsequent discussion with their substitute decision makers.

The service has also demonstrated it has policies and procedures are reflective of current legislation and accepted best practice, evident through reference to recent legislation amendments, Dementia Support Australia resources, and Commission resources.

However, the Assessment Team found the service continued to be unable to demonstrate an effective clinical framework for minimising restraint and assert that the service does not recognise the use of chemical and environmental restraint in accordance with legislative requirements. The Approved Provider refuted the Assessment Team’s findings and supplied accompanying documentation to support their reasoning. I have considered both perspectives and related evidence below.

I note the organisation’s policy does refer to use of restrictive practice as a last resort, however, the Assessment Team found that the service has not demonstrated antipsychotic medication is used only as a last resort for 4 consumers, suggesting a failure in the organisation’s clinical framework. I am unable to form a definitive view on this finding, as there is insufficient information presented in either the Assessment Contact report or Approved Provider’s response to make a determination given the case-by-case nature and documentation required to show alternative strategies have been trialled prior to use of a restrictive practice. Service management has noted that psychotropic use is monitored by the service and reviewed quarterly or as required by Medical Officers, however, this has only been partially demonstrated through supplied progress notes.

I also note (related to the above), that for some consumers, documentation relating to restrictive practices has not been completed, however, I have considered the Approved Provider’s reasoning that this has not occurred as the service does not consider the named consumers to be subject to restrictive practices. As above, I am unable to form a view on whether the documentation should have been completed, given the individual or case-by-case consideration approach required to determine if use of a psychotropic medication is or is not a chemical restraint.

However, there is some evidence of deficiencies relating to minimisation of restrictive practices which I have considered and relied upon in making my finding of whether the organisation’s clinical framework is effective, including:

For one consumer, goals and intervention strategies listed in supplied care documentation to manage their verbal and physical behaviours are generic, rather than person-centred.

Care planning documentation accompanying the Approved Provider’s response does not clearly identify the clinical indication for each psychotropic medication per the prescriber’s prescription, and whether the medication is being used for the primary purpose of influencing the consumer’s behaviour. I have considered that this information may be documented elsewhere, however, this has not been demonstrated by the Approved Provider.

While the organisation’s policy refers to regular evaluation and reassessment, it has not been clearly demonstrated whether the service is undertaking this in all cases. Evidence provided by the service in relation to one consumer dates to 2019 and 2020, which, while this information may still be accurate, does not demonstrate/confirm contemporary assessment/reassessment of a consumer’s individual scenario.

The Assessment Team found 2 consumers have undergone a change in mobility since their admission, however, the service has not demonstrated reassessment of their environmental restraint. A broad-brush approach appears to have been used to establish that all consumers are subject to environmental restraint by virtue of the secure environment, rather than an individualised approach. This is incongruent with the intent of this Requirement in minimising restrictive practices.

I have also considered other aspects demonstrating the Approved Provider’s performance against this Requirement, including:

The service has shown it has behaviour support plans completed for sampled consumers and informed consent has been recorded in accordance with the service’s policy and procedure. I acknowledge the Approved Provider’s response noting that organisational policy and procedure will be reviewed, in addition to other planned actions as outlined on the supplied action plan for continuous improvement.

In relation to antimicrobial stewardship, the organisation demonstrated it has a relevant policy targeting appropriate use of antimicrobials, a process for training staff and ensuring staff awareness of antimicrobial stewardship, and a system for monitoring use of antibiotics through monthly infection reporting. There is external involvement with prescribing physicians and evidence that the service monitors and analyses its performance to reduce antibiotic use where it is not appropriate.

In relation to open disclosure, the organisation has demonstrated policy and systems which support communication with consumers following incidents. Evidence of staff following organisational policy has been provided.

While the service has demonstrated some understanding and application of this Requirement and made improvements following the previous performance assessment, on balance of the evidence presented, I have found insufficient evidence demonstrating consistent recognition of restrictive practices occurs, and subsequently that organisational systems support minimisation of restraint in both a holistic and individualised approach.

Subsequently, I find the Approved Provider Non-compliant with this Requirement.

As this Requirement has been found Non-compliant, the overarching Standard is accordingly Non-compliant.

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