Performance

Report

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| Name: | Macleay Valley House |
| Commission ID: | 0946 |
| Address: | 80-114 Macleay Street, Frederickton, New South Wales, 2440 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 30 January 2024 to 1 February 2024 |
| Performance report date: | 6 March 2024 |
| Service included in this assessment: | Provider: 372 Thompson Health Care Pty Ltd  Service: 6224 Macleay Valley House |

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 Macleay Valley House (**the service**) has been prepared by G-M. Cain, 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 (performance assessment) – site 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 23 February 2024, and subsequent information (after request from the decision maker) on 29 February 2024.
* the Aged Care Quality and Safety Commission’s ‘[Perimeter restraint self-assessment tool](https://www.agedcarequality.gov.au/sites/default/files/media/Perimeter%20Restraint%20Scenarios.pdf)’

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 3(3)(a) – The approved provider must demonstrate consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being. Restrictive practice processes are best practice, including used as a last resort, and with informed consent from the consumer and/or representative.
* Requirement 8(3)(e) – The approved provider must demonstrate the clinical governance framework implemented at the service is effective in ensuring safe and quality clinical care to consumers. This includes the identification and minimising the use of restrictive practices.

# 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. | 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

The performance report dated 15 September 2023 found the service non-compliant in three Requirements under Standard 2:

* + Requirement 2 (3)(a)
  + Requirement 2 (3)(d)
  + Requirement 2 (3)(e)

Deficiencies related to assessment and planning not consistently considering the risks to the consumer’s health and well-being; that outcomes of assessment and planning are not effectively communicated or made readily available to the consumers; and the inconsistent review of consumer care and services, including when circumstances changed.

The Assessment Contact Report contained information which identified the service demonstrated actions to improve its performance under these Requirements. Consumers and representatives spoke positively about the assessment and care planning process, including the service effectively communicating any changes with them. Care documentation identified the completion of consumer risk assessments and the reassessment and review of consumers regularly and in the event of a change to their health and/or wellbeing. Most consumers were aware of the availability of a copy of the consumer care plan if they wished. Care documentation identified overall, risk assessments for consumers were complete, and staff described how they considered risks in the assessment and care planning process. When an incident occurred, or there was a change to consumers’ condition, care documentation evidenced reassessment and review of the consumer; in the event of an incident notification was made to clinical management.

Improvement actions included:

* A review of the clinical care management at the service to ensure ongoing support to the clinical team, this included training and coaching in care planning.
* Review of the care planning and evaluation process, including 3 monthly care assessments which is overseen by clinical management. This included the development of a care plan review schedule and a review of all consumers’ care plan to ensure these reflected consumers’ needs.
* Communication and discussions with consumers and representatives are documented in the electronic care documentation system, and a copy of the care and services plan is provided prior to case conferences.

I have considered the Assessment Contact Report alongside the response submission, it is my decision that Requirement 2(3)(a), Requirement 2(3)(d) and Requirement 2(3)(e) are Compliant.

# 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. | Not 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)(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

The performance report dated 15 September 2023 found the service non-compliant in six Requirements under Standard 3:

* + Requirement 3 (3)(a)
  + Requirement 3 (3)(b)
  + Requirement 3 (3)(d)
  + Requirement 3 (3)(e)
  + Requirement 3 (3)(f)
  + Requirement 3 (3)(g)

Deficiencies related to:

* A lack of shared understanding of restrictive practices including the effective monitoring of consumers subject to restrictive practices, and wound care documentation not consistently providing clear guidance or record wound deterioration;
* The inconsistent management of high impact or high prevalence risks including in relation to the management of catheters, restrictive practices, diabetes, and risks related to unplanned weight loss;
* The deterioration or changes in consumers’ mental, cognitive or physical function, capacity or condition not consistently being identified;
* Consumer condition, needs and preferences not consistently communicated within the organisation and with others where responsibility is shared, including consumer care plan not reflecting each consumers’ current needs and preference;
* The service did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services where required;
* The service not demonstrating effective systems for minimising infection-related risks, including an appropriately trained infection management and prevention lead.

*In relation to Requirement 3(3)(a)*

The Assessment Contact Report contained information relating to deficiencies in the clinical care of consumers with changed behaviours and those subject to restrictive practices, specifically consumers prescribed psychotropic medication and consumers subject to environmental restrictive practice; risks associated with the use of a bed pole for one consumer and wound management.

In relation to restrictive practices, the service’s clinical risk register, provided as part of the response submission identified:

* Consumers prescribed a regular psychotropic medication: 73
* Consumers prescribed an ‘as required’ psychotropic medication: 50
* Consumers subject to ‘pharmacological restraint’: 17
* Consumers subject to ‘mechanical restraint’: 7
* Consumers subject to ‘physical restraint’: 39

Chemical restrictive practice and changed behaviour

For one named consumer, a review of care documentation (1 November 2023 to 28 January 2024) identified the administration of 2 psychotropic medications and Schedule 8 medication for pain management. When administered ‘as required medication’, this was not consistently evaluated and staff did not consistently implement non-pharmacological strategies prior to the administration of a psychotropic medication. I have considered this information alongside the approved provider's response, which provided clarifying information, including (but not limited to) copies of medication charting, progress notes, pain assessments and consent forms, noting the information provided was dated from 1 January 2024. The response submission identified:

* On most occasions, the evaluation of the effectiveness of as required medication (including psychotropic and other) was recorded and charting identifies those non-pharmacological strategies, including assessment of pain and repositioning, were implemented as described in the consumers’ behaviour support plan.
* The consumers’ behaviour support plan identified triggers for changed behaviours included pain and feeling unwell. The named consumer experienced a change in behaviour, 01 January 2024 and I am satisfied the response submission evidenced appropriate assessments, care plan review and referrals to the medical officer and other specialists.
* In relation to the administering of 2 psychotropic medications and Schedule 8 pain medication, the response submission evidenced, and I am of the view, that the administration of these were in accordance with the indication/s as prescribed by the medical officer.
* A psychotropic medication consent form for the named consumer identified appropriate assessment and authorisation from the consumer’s representative.

The Assessment Contact report contained information that chemical restrictive practice was not consistently used as a last resort in line with best practice and pain was not always considered as a trigger for her behaviours. I have considered the name consumer above, however, in relation to other consumers subject to chemical restrictive practices, the Assessment Contact report did not include specific evidence to corroborate these statements.

Environmental restrictive practice

The service’s clinical risk register did not identify consumers’ subject to environmental restrictive practice. However, I have considered the service has identified consumers subject environmental restrictive practice under physical restraint.

In relation to environmental restrictive practice at the service, the Assessment Contact report contained information that the service had identified some consumers were subject to environmental restrictive practice (26 consumers residing in the secure living environment). However, other consumers at the service are or may be subject to an environmental restrictive practice as observations showed pin coded keypad at the front door of the service and consumers could not exit the service independently. The response submission included evidentiary photographs, and stated after the fixing of mechanisms, the door at the front of the service is unlocked and now opens automatically on entry and exit. I acknowledge this does allow consumers to move independently both inside and outside of the service, however, I have considered the response submission that states (in relation to the front doors), ‘the doors were manually closed after hours for security once all residents had retired for the evening. Late at night residents can leave the service with the assistance of staff at any time but to date the service has not identified any resident requiring this assistance’. In considering my decision in relation to this matter, I referenced the Commission’s ‘[Perimeter restraint self-assessment tool](https://www.agedcarequality.gov.au/sites/default/files/media/Perimeter%20Restraint%20Scenarios.pdf)’ which states, a person is subject to a restrictive practice ‘if they are unable to leave their room or facility but don’t pose a risk to themselves or others. They could leave and return safely *but they need a mechanism or a go-to person to assist them with the door’*. It is my view that consumers at the service (who reside in the general area of the service) are or may be subject to environmental restrictive practice, my reasons being as regardless of the time of day, if the front door is locked and the consumer requires the assistance of staff to open the front door this is considered a restrictive practice. In relation to a service wide oversight of restrictive practices, the Assessment Contact report identified deficiencies and I have considered this information under my decision for Requirement 8(3)(e).

For a second named consumer, the Assessment Contact report contained information that the utilisation of a bed pole for the consumer did not include relevant assessment and review by a qualified health professional to ensure consumer safety and in alignment with best practice. I have considered this alongside the response submission and come to a different view, the response submission evidenced the completion of a bed pole assessment dated 28 December 2023 and a dignity of risk assessment dated 1 January 2024. I am satisfied the service has taken appropriate actions to ensure the safety of the consumer, considered best practice and discussed risks.

For a third named consumer, the Assessment Contact report identified staff were not following directives for the management of the consumer’s wound, including the incorrect assessment of a pressure injury and the recurrence of the pressure injury not recorded on an incident form. I have considered this alongside the response submission, which included assessments, progress notes, photographic evidence and clinical incident forms which evidenced:

* ongoing assessment of the consumer’s skin including the identified pressure injury on the sacrum.
* a wound and skin management plan which included directives for wound management such as dressing selection, frequency of evaluation and weekly photographs.
* the completion of a clinical incident form dated 1 February 2024.

In relation to the incorrect assessment of the pressure injury, I have not considered this specifically in my decision, I am of the view that regardless of the assessed stage, I am satisfied the service has demonstrated monitoring and management of the wound, and documented strategies such as second hourly repositioning to ensure safe care to the consumer.

In coming to my decision for this requirement, I acknowledge the improvements made by the service in this Requirement in relation to wound management and some elements of restrictive practice such as the review of consumers prescribed psychotropic medications and increased oversight through the reporting as evidenced in the Assessment Contact report. This requirement requires that each consumer gets safe and effective personal care and/or clinical care that is best practice tailored to their needs and optimises their health and well-being. The service has not demonstrated effective management of consumers subject to environmental restrictive practice. Therefore, it is my decision requirement 3(3)(a) is non-compliant.

For the remaining Requirements, the service demonstrated actions to improve its performance.

Consumers and representatives considered the service effectively managed high-impact, high-prevalence risks associated with the care of consumers, with strategies to mitigate risk. Staff explained how they minimised individual risks to consumers. Care planning documents demonstrated high-impact, high-prevalence risks were assessed and monitored, and risk mitigation strategies were implemented. The service monitors key clinical indicators related to incidents to ensure the identification of high impact and high prevalent consumer risk such as falls, pressure injuries and behaviours, psychotropic medication usage, unplanned weight loss and restrictive practice.

For most consumers, the service demonstrated processes to ensure the timely recognition and response to consumer changes and/or deterioration. Management and staff described the processes in identifying, and reporting changes in consumers. Care documentation reflected the identification of, and response to, deterioration or changes in their condition, including referral to the medical officer if appropriate. The Assessment Contact report contained information in relation to one named consumer, where the service did not respond to deterioration in a timely manner, and I have considered this under my decision for Requirement 8(3)(d).

Consumers and representatives were satisfied that consumers' care needs and preferences were effectively communicated among staff. Care documentation demonstrated that progress notes, care and service plans, and handover reports provide adequate information to support the effective and safe sharing of consumer information. Staff described how consumer care and service changes are communicated in the service's electronic care documentation system, at shift handover and daily meetings.

Consumers have access to relevant health professionals, and referrals are timely, appropriate and occur when needed. Care documentation indicated the input of other health professionals, such as medical officers, dietitians, and specialist services.

The service has documented policies and procedures to support minimising infection-related risks, including an outbreak management plan and antimicrobial stewardship. Clinical staff understood the principles of antimicrobial stewardship, outbreak management and standard precautions. Observations showed staff practising handwashing and sanitisation, and consumer care documentation and service documentation identified the implementation of preventative measures to mitigate risk of reoccurrence.

It is my decision that Requirement 3(3)(b), Requirement 3(3)(d), Requirement 3(3)(e), Requirement 3(3)(f) and Requirement 3(3)(g) are Compliant.

# Standard 6

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| Feedback and complaints | |  |
| 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

The performance report dated 15 September 2023 found the service non-compliant in two Requirements under Standard 6:

* + Requirement 6 (3)(c)
  + Requirement 6 (3)(d)

Deficiencies related to the service being unable to demonstrate that concerns raised by consumers or representatives are effectively addressed, or that feedback and complaints are reviewed and used to improve the quality of care and services for consumers.

The Assessment Contact Report contained information which identified the service demonstrated actions to improve its performance under these Requirements.

Overall, consumers and representatives were satisfied with the service’s actions taken in response to complaints, including an apology by management when things go wrong. The service has an established a consumer advisory meeting which is held monthly and provide feedback and complaints to management on behalf of consumers at the service. Staff described and provided an example of open disclosure in practice relating to an incident involving a named consumer. Consumers and representatives expressed satisfaction that the service is using complaints and feedback to improve care and services, and this was supported by evidence contained in ‘resident and representative’ meeting minutes. Management spoke of feedback and complaints being analysed to identify trends and improvements in the quality of care and services. Complaints trending and analysis reports are displayed on noticeboards and monthly reports to the Board include performance related to feedback and complaints.

It is my decision that Requirement 6(3)(c) and Requirement 6(3)(d) are Compliant.

# 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)(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

The performance report dated 15 September 2023 found the service non-compliant in four Requirements under Standard 7:

* + Requirement 7 (3)(a)
  + Requirement 7 (3)(c)
  + Requirement 7 (3)(d)
  + Requirement 7 (3)(e)

Deficiencies related to staff shortages, with examples of this negatively impacting on the delivery of care and services for consumers; the workforce not having the qualifications and knowledge to perform their roles, including being provided appropriate education and training to effectively perform their roles.

The Assessment Contact Report contained information which identified the service demonstrated actions to improve its performance under these Requirements.

Of the 25 consumers and representatives interviewed, most advised there was an adequate number of staff available and that requests for assistance were answered in a timely manner. Five consumers did raised feedback relating to waiting extended periods for staff, and I am satisfied that the service demonstrated immediate actions to rectify to ensure the delivery of safe and quality care to consumers. Management feedback and documentation demonstrated monitoring processes, such as review of call bell response times, and maintained oversight of the deployment of appropriate number and mix of staff across the service. The staff roster included a sufficient mix of staff across all areas of service delivery, including the use of agency workforce as required, and systems were in place to account for unplanned leave.

Consumers spoke of staff being competent in performing their roles and knowing what they are doing. The service had policies, procedures, staff training, and systems to ensure staff were qualified, and had up-to-date qualifications and knowledge to effectively perform their role. Management explained they maintained oversight of staff competency through annual competency assessments, review of clinical incidents and direct observations of staffs’ practices by clinical management. Role descriptions were evidence for all positions and understanding of these roles were demonstrated by staff when interviewed.

The workforce was supported to deliver the outcomes required by these standards through formal recruitment processes. Staff confirmed they received training during their orientation and induction and regularly throughout the year which included training in the Aged Care and Quality Standards. Staff training records evidenced training provided to the workforce including the Serious Incident Response Scheme, infection control and the Aged Care Code of Conduct.

Service documentation and interviews with management evidence staff performance was reviewed regularly, and included assessment, review and feedback. And while documentation identified not all staff had completed a performance appraisal, staff performance is continuing to be monitored via observations and review of incidents, and the service demonstrated a plan for completion of all appraisals by June 2024. The service demonstrated processes for the monitoring and management of staff where areas of improvement in performance had been identified, included education and close supervision.

It is my decision that Requirement 7(3)(a), Requirement 7(3)(c), Requirement 7(3)(d) and Requirement 7(3)(e) are Compliant.

# 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. | Not Compliant |

Findings

The performance report dated 15 September 2023 found the service non-compliant in five Requirements under Standard 8:

* + Requirement 8 (3)(a)
  + Requirement 8 (3)(b)
  + Requirement 8 (3)(c)
  + Requirement 8 (3)(d)
  + Requirement 8 (3)(e)

Deficiencies related to mechanisms to engage consumers in the development, delivery and evaluation of care and services; the governing body did not demonstrate it had not promoted a culture that ensures safe and quality care and services or ensured mechanisms are in place to ensure it is accountable for their delivery; the organisation did not demonstrate effective organisation wide governance systems in place including risk management and clinical governance.

*In relation to Requirement 8(3)(d)*

The Assessment Contact Report contained information that the organisational risk management systems and review processes were not effective in the outcomes of critical incidents being used to change practice and processes at the service. Specifically, relating to:

* One named consumer (with left sided weakness) who had experienced a burn as a result of spilling soup onto themselves on 1 January 2024. While the service had undertaken a critical incident on 3 January 2024, which included the review of food temperatures, the Assessment Contact report identified a risk assessment in relation to the consumer’s ability to independently eat hot foods (due to right sided weakness) had not been completed; and the incident had not been reported under the Serious Incident Response Scheme until 25 January 2025.
* A second name consumer, and the utilisation of a bed pole for the consumer without relevant assessment and review by a qualified health professional to ensure consumer safety and in alignment with best practice. I have considered this under my decision for Requirement 3(3)(a) and I am satisfied the service has taken appropriate actions to ensure the safety of the consumer and minimise risks.
* With the service commencing with admission of consumers, the risk management approach to ensure a sufficient workforce, equipment and clinical staff to meet the needs of the consumers.

Requirement 8(3)(d) requires organisations to have systems and processes to identify and assess risks to the health, safety and well-being of consumers, to minimise and manage risks, and to respond to incidents to support the safety and well-being of consumers. In coming to my decision for this requirement, I have considered this alongside the Approved Providers response submission, and have come to a difference decision, I find Requirement 8(3)(d) is Compliant. The response submission evidenced:

* Immediate actions taken in response to the named consumer who had experienced a burn, including the notification of the incident as Priority 2 under the Serious Incident response scheme which occurred within the 30-day reporting timeframe as required. I note, the response submission included a ‘DON December 2023’, which identified the appropriate reporting of an incident relating to medication management as a Priority 1 notification, and 4 other Priority 2 incidents. I am satisfied that the organisation does have effective processes to manage and prevent incidents, including the use of an incident management system. I have placed weight on evidence contained in the Assessment Contact record under Requirement 3(3)(b) which identified the service demonstrated systems and processes are in place to identify and manage high impact and high prevalence risks.
* In relation to outcomes of critical incidents being used to change practice and processes at the service, there is a lack of evidence in the Assessment Contact report to identify this did not occur. The response submission evidence care documentation that includes strategies to implement by staff to minimise associated risks including for example, positioning the consumer upright before meals and standby assistance.
* In relation to the service’s admission’s risk assessment approach, the response submission provided commentary as to the service’s planned approach to consumer admission’s and supports to ensure appropriate assessment and care planning for consumers, support for staff at the service through attendance of clinical consultants and monitoring of new consumers’ assessment and care planning through audits and weekly leadership meetings.

*In relation to Requirement 8(3)(e)*

The Assessment Contact Report contained information that the organisation’s clinical governance was not effective in relation to restrictive practices at the services, specifically one named consumer prescribed psychotropic medications were this was not used as a last resort; and consumers at the service subject to environmental restrictive practices not identified.

In coming to my decision in relation to restrictive practices, I have considered information contained in the Assessment Contact report under this and other Requirements. I acknowledge the organisational systems and processes in relation to the monitoring and management of restrictive practices, as evidence in the Assessment Contact report and response submission including reporting to the Commission, monthly service reporting to the Board (via the organisational quality team), the service’s clinical risk register and the provision of education to the workforce in restrictive practices. The service has demonstrated improvements in its system and processes related to restrictive practices, including review of consumers subject to restrictive practices, the completion of consents, increased oversight of consumers by clinical management including consumers prescribed psychotropic medication and the review of care documentation to ensure staff are guided and restrictive practices are used as a last resort. However, whilst improvement to the organisational systems and processes is evidenced, the service has not identified all consumers who are or may be subject to environmental restrictive practices.

The service demonstrated the implementation of improvements relating to anti-microbial stewardship, the implementation of a random audit program, review of the clinical indicator data and external benchmarking.

It is my decision that Requirement 8(3)(e) is Non-compliant.

For the remaining Requirements, the service demonstrated actions to improve its performance.

The service demonstrated the involvement of consumers in the development, delivery, and evaluation of care and services provided to them. Management explained how consumers were engaged in the development, delivery, and evaluation of care and services, such as surveys, feedback mechanisms, and meetings. The service’s plan for continuous improvement evidenced improvements take by the service.

The organisation implemented systems and processes to monitor the performance of the service, and to be accountable for the delivery of safe, inclusive, quality care and services. Management explained the service’s performance, and relevant data, and other information were captured and included in various reports. The reports were reviewed by the governing body and used to identify the service’s compliance with the Quality Standards, and initiate improvements. The organisational has a Diversity Plan which includes priorities and strategies to support consumers in accessing information, making informed choices, supporting a proactive and flexible workforce, tailoring services to meet diverse needs, respectful and inclusive services, attracting and developing a diverse workforce.

Organisation wide governance systems were effectively supported by policies, procedures, training, audits and reporting mechanisms, relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, feedback and complaints. Staff demonstrated knowledge of the organisation-wide governance systems, and information contained in the Assessment Contact report corroborated this through service documentation and interviews with management and staff.

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