Performance

Report

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| Name of service: | Manly Vale Nursing Home |
| Service address: | Cnr Condamine St & Gordon St MANLY VALE NSW 2093 |
| Commission ID: | 2603 |
| Approved provider: | Manly Vale Nursing Home Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 6 September 2022 to 9 September 2022 |
| Performance report date: | 26 October 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 Manly Vale Nursing Home (**the service**) has been prepared by M.Nassif, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the site audit, the site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 12 October 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-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 3(3)(b) – The Approved Provider ensures that high impact risks to consumers, including restrictive practice, diabetes and falls, is managed effectively.
* Requirement 8(3)(c) – The Approved Provider ensures that there is informed consent from consumers or their substitute decision maker for restrictive practices, and behaviour support plans are in place for all consumers subject to restrictive practice.
* Requirement 8(3)(d) – The Approved Provider ensures that incidents are reviewed, evaluated, monitored, and any incidents are reported through the Serious Incident Response Scheme (SIRS) and documented in the service’s clinical incident records.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers said they are treated with dignity and respect, their identity, culture, and diversity is valued. Staff described what is important for consumers and how they interact with them to promote dignity and respect. Care planning documents included information on consumers’ identity.

Consumers and representatives said staff respect consumers’ cultural background and spirituality. Care planning documents identified consumers’ religion, language spoken and cultural background and other specific beliefs. Staff demonstrated knowledge of consumers’ spiritual preferences.

Consumers and representatives expressed satisfaction on how the service provides consumers with choices regarding their care and services, and that the service encourages consumers to make connections and maintain relationships. Care planning documents identified consumers’ individual choices around when care is delivered, who is involved in their care and how the service supports them in maintaining relationships.

Consumers described how the service supports them in making decisions that involve taking risks. Staff described the risks taken by consumers, and what they do to minimise the risks. Care planning documents reflect decisions and activities taken by those consumers that involve risks, and the strategies in place to mitigate the identified risks.

Consumers expressed satisfaction in how the service communicates information to assist them make informed choices, and said the communication is timely, clear, and easy for them to understand. Staff described several means of communication they utilise in the service, including phone calls and emails.

Consumers and representatives felt confident consumer information was kept confidential. Staff described how they maintain a consumer’s privacy when providing care and how they keep person information confidential. Staff were observed knocking on bedroom doors and awaiting a response before entering.

# 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)(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

Consumers and representatives expressed satisfaction with the assessment and care planning processes and the care and services consumers receive. Staff described their role in the assessment and planning process when a consumer enters the service, and the ongoing review process. Care planning documents demonstrated the service considers risks for consumers when completing assessments. However, some consumers who have a chemical or environmental restrictive practice did not have a behaviour support plan in place. This evidence is considered under Requirements 3(3)(b) and 8(3)(c) where is it more relevant.

Consumers and representatives felt assessment and planning addresses consumers’ needs, goals, and preferences. Care planning documents included advance care and end of life planning if the consumer wishes.

Consumers and representatives confirmed they are involved in the assessment and care planning process. Care planning documents reflected the involvement of consumers, representatives and other health professionals in the assessment and planning process. Staff described the process for referral to allied health professionals.

Consumers and their representatives said staff explain information about care and services, they can access a copy of the consumer's care and service plan when they want to. Staff described processes for documenting and communicating outcomes of assessments.

Care planning documents evidenced care and services are reviewed for effectiveness every 12 months and when circumstances change or when incidents impact the needs, goals, and preferences of consumers. Staff described the process for regular review of care and services and when circumstances change.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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

The Assessment Team recommended that Requirements 3(3)(a), (b) and (d) were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 3(3)(a), the Site Audit Report identified the following deficiencies:

* Restrictive practices are not being appropriately monitored, appropriate consent is not in place and consumers do not have an individualised behaviour support plan that included strategies to support managing their behaviours.
* The service did not provide care that was tailored to a named consumer’s pain after a falls incident.

Both deficiencies were discussed and considered in the Site Audit report under Requirements 3(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). I have considered these deficiencies under those requirements where it is more relevant.

Overall, care planning documents demonstrated that consumers receive tailored personal and clinical care to optimise their health and wellbeing and staff shared an understanding of consumers’ care needs in line with care plans. Consumers and representatives said they are confident consumers’ personal and clinical care needs are met. The evidence provided by the Assessment Team in this requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 3(3)(a) compliant.

Regarding Requirement 3(3)(b), the Site Audit Report identified several deficiencies. I consider the following relevant to Requirement 3(3)(b):

* Five consumers, with one named consumer provided as an example, who are receiving chemical or environmental restrictive practice after displaying reactive behaviours did not have a behaviour support plan.
* The behaviour support plan for 3 consumers did not record response strategies or non-pharmacological strategies that were tailored to the consumer's needs.
* The service has not monitored and recorded blood glucose levels (BGL) for 1 named consumer in line with their diabetic management plan.
* One named consumer’s diabetic management plan did not include BGL parameters and guidance on what staff should do if the consumer’s BGL is outside the parameters.
* For one consumer who had a near fall incident involving a shower chair, the incident was closed as the service could not identify exactly what had happened. There was no evidence of further assessment or evaluation of the incident to mitigate or prevent risk of future occurrence.

The provider’s response and Site Audit report provided clarifying information for some of the deficiencies identified in the Site Audit report:

* In relation to the one named consumer provided as an example of a consumer who is subject to restrictive practice without a behaviour support plan, the response provided evidence that the consumer does have a behaviour support plan in place. However, the response did not address whether behaviour support plans are in place for all consumers subject to restrictive practice.
* In relation to the consumer whose diabetic management plan did not include BGL parameters, the Site Audit report states management advised weekly BGL checks had resumed. However, the response did not address if the consumer’s diabetic management plan was reviewed or updated to include BGL parameters and guidance to staff on what to do should the consumer’s BGL fall outside the parameters.
* In relation to the other consumer whose BGL was not monitored and recorded in line with their diabetic management plan, the response provided contradictory information in relation to whether the consumer’s BGL was in fact monitored. I have relied on the Site Audit report’s findings and I am not satisfied appropriate BGL monitoring occurred in relation to the named consumer. No further evidence was provided in the response in relation to directives from a medical officer or on when BGLs should be monitored. The Site Audit report states that the consumer presented with 2 episodes of low BGL after the time the consumer’s BGL was supposed to be checked in accordance with their plan and was then transferred to hospital. While I acknowledge the service responded to the consumer’s low BGL episode promptly and appropriately, as considered under Requirement 3(3)(d), this is evidence that the service is not effectively managing the consumer’s high impact risks in relation to their diabetes.

The provider’s response did not address the 3 consumers whose behaviour support plan does not record non-pharmacological strategies.

The response did not directly address the named consumer who had a near falls incident.

I acknowledge the provider’s response with clarifying information for some of the deficiencies identified in the Site Audit report, however I consider that not all deficiencies were addressed, and the service was not able to demonstrate that high impact risks to consumers, including restrictive practice, diabetes and falls, is managed effectively. Therefore, based on the evidence before me, I find Requirement 3(3)(b) non-compliant.

Regarding Requirement 3(3)(d), two occasions were identified where the deterioration of a consumer or changes in the consumer’s condition were not promptly recognised and responded to appropriately:

* One consumer had an unwitnessed fall resulting in a fractured ankle that was not identified until several days later.
* One consumer had 2 low BGL events where the consumer was given glucagon after the first event and a medical officer was notified, however there was no further information in relation to a medical officer’s input. After the second event the consumer was sent to hospital.

The provider’s response provided clarifying information in support of compliance:

* In relation to the named consumer who had an unwitnessed fall, the response evidenced that the consumer was appropriately assessed immediately after the fall. The response also evidenced that once the consumer had shown signs of pain and swelling several days after the incident, staff referred the consumer to a medical officer for review, and an x-ray was arranged.
* In relation to the named consumer with 2 low BGL events, the Site Audit report states that glucagon was administered after the first event that the consumer’s BGL was low. The response states that, in relation to the second event, after the consumer’s BGL was low again and staff recognised other clinical symptoms of low BGL, staff took immediate action such as administering glucagon and providing oxygen to the consumer and calling an ambulance should the glucagon not work.

The evidence provided by the Assessment Team in this requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 3(3)(d) compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 3 are compliant.

Care planning documents for consumers who were nearing end of life showed their needs, goals and preferences are recognised, and their comfort maximised. Staff described the way care delivery changes for consumers nearing end of life. Consumers and representatives expressed confidence that when consumers require end of life care, the service will support them to be as free as possible from pain and to have those important to them with them.

Progress notes, care and service plans and handover reports provided adequate information to facilitate effective and safe sharing of consumers' information to support care. Staff said they use the handover process to discuss consumers’ needs and changes and document these in care planning documents.

Consumers and their representative’s said referrals are timely, appropriate and occur when needed. Staff described the process to refer clinical matters to other providers. Care planning documents evidence referral to allied health professionals occur.

The service had policies and procedures to guide staff in antimicrobial stewardship, infection control management, and the management of a COVID-19 outbreak. Staff described how infection related risks are minimised, antibiotics are used appropriately, and infection control procedures are followed.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and representatives said consumers receive safe and effective services and supports for daily living, including activities of interest that optimises their independence and well-being. Staff explained how the service brings community events into the facility and uses technology to maximise consumer engagement and enjoyment. Care planning documents identified strategies to safely maintain consumers’ best possible level of independence and function.

Consumers said they can stay in touch with family or friends which aids on minimising the risk of stress, depression, and anxiety. Staff described how they support consumers’ emotional, social, and psychological needs.

Consumers and representative said consumers are supported to stay connected with the people who are important to them, participate in the community and maintain relationships. Care planning documents identified how consumers wish to participate in activities, outings and maintain relationships.

Consumers and representatives expressed satisfaction on how the service uses and shares consumer information in relation to their condition, needs and preferences, and include others where responsibility for care is shared. Staff described how changes in consumers’ care and services are communicated, and care planning documents provided adequate information to support effective and safe sharing of consumers’ care.

Consumers and representatives felt supported by the service and providers of other care and services. Care planning documents identified referral to other organisations and services, and progress notes confirmed that staff assist consumers to access these services.

Consumers said they are provided with varied meals of suitable quantity and quality in line with their needs and preferences. The service chef said they update menu choices and the dietary matrix to reflect changes made by the dietitian or speech therapist, and that those changes are communicated, and all internal records are updated.

Equipment which supported consumers to engage in lifestyle activities was observed to be suitable, clean and well maintained. Consumers confirmed this to be the case and staff described the process for reporting faulty equipment.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team recommended Requirement 5(3)(b) was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 5(3)(b), the Site Audit report identified as a deficiency that consumers residing on level 1 of the service had no outdoor access to external areas, except if they came to the courtyard located on the ground floor by the pass coded lift.

The provider’s response reiterated management’s feedback identified in the Site Audit report which outlines corrective actions that was taken in support of compliance for this Requirement. This included removing the pass code required to move between levels, so consumers are able to move freely between all levels without the assistance of staff. The response also states that for consumers who are unable to use the lift independently, staff can escort them between levels and to access outdoor areas.

The evidence provided by the Assessment Team in this requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 5(3)(b) compliant.

I am satisfied the remaining 2 Requirements in Quality Standard 5 are compliant.

Consumers said it was easy to move around the service, and they feel at home. The Assessment Team observed the service environment is personalised to show the consumer’s personality and individuality if they prefer, and reflects that the service is their home.

Furniture, fittings, and equipment were observed to be safe, clean, and well maintained. Maintenance records evidenced maintenance issues raised were actioned, call bell checks conducted, and records of attendance of third-party contractors such as pest control, fire safety, high cleaning were in place.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives said they are encouraged to provide feedback have no issues talking with management should they have a concern. Noticeboards and the service’s publications contained information on how to make a complaint, and feedback and suggestion collection boxes are available for consumers, visitors, or staff to submit comments and complaints form.

Consumers said they were aware of advocacy services if needed. Staff described how they assist consumers with a cognitive impairment or difficulty communicating to raise a complaint or provide feedback.

Consumers and representatives said the service addresses and resolves their concerns following the making of a complaint, or when an incident has occurred. Staff said if consumers and representatives raised an issue with them directly, they escalate all complaints to management for investigation and follow-up.

Management team demonstrated how feedback and complaints are linked to the service’s continuous improvement plan. Management described how comments and complaints received is acknowledged and entered into the electronic management system which also registers improvements made in response to feedback.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Assessment Team recommended Requirement 7(3)(d) was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 7(3)(d), the Site Audit identified the following deficiencies:

* Behaviour and restrictive practices training was last delivered in 2020.
* The service had not conducted training for staff on open disclosure or the Serious Incident Response Scheme (SIRS).
* Staff attendance of mandatory education was low, and management did not have a program or process to follow up.

The provider’s response:

* Stated that the service’s records, though the records themselves are not provided in the response, indicates that the most recent training in relation to SIRS and restrictive practices was September 2022.
* Does not address staff training in relation to open disclosure however highlighted that the Site Audit report stated under Standard 6 that an open disclosure process is used, and this is indicative of staff with sound knowledge of open disclosure.
* Refers to comments made by staff about the requirement to complete mandatory training and how this is monitored by management but does not directly address the low staff attendance or management’s process to follow up with staff.

I consider the provider’s response is not persuasive. However, overall the Site Audit report stated the service demonstrated that it had implemented appropriate systems and processes to ensure that appropriately trained and skilled staff are recruited and supported to deliver quality care and services. Consumers and representatives also said staff know what they are doing and are well trained.

I have given greater weight to feedback from consumers and representatives and that no consumer impact was identified by the Assessment Team as a result of deficits in training. The service demonstrated it had a recruitment and training framework to ensure qualified staff are recruited and staff are provided training to perform their roles. Therefore, based on the evidence before me, I consider Requirement 7(3)(d) compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 7 are compliant.

Consumers felt there is enough staff, and that staff are not rushed when they are providing care, call bells are answered promptly, and staff give them the care they need. The staff roster demonstrated that the service ensures there is enough staff to provide continuous safe and quality care, and management provided evidence of strategies in place for any impacts on staff availability.

Consumers said staff are kind, caring and respectful, and they respect their identity, culture, and diversity. Staff were observed being kind and respectful to consumers and asking consumers for their preferences.

Consumers and representatives felt staff are well trained and meet the needs of consumers in a friendly and helpful manner. Members of the workforce have the qualifications and knowledge to perform their roles effectively. Records evidenced the service maintains an up-to-date register of staff qualifications and reviews this regularly.

Management advised staff performance is formerly reviewed at least once a year using a formal performance appraisal process. Staff demonstrated awareness of performance monitoring processes, including discussion of their performance and areas where they would like to develop their skills and knowledge.

# 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. | 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. | 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 Assessment Team recommended Requirements 8(3)(a), 8(3)(b), 8(3)(c), and 8(3)(d) were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 8(3)(a), the Site Audit report states that there was no evidence from minutes of meetings or through interviews with consumers that they were engaged in the development, delivery and evaluation of care and services.

The provider’s response disagreed with this recommendation and provided clarifying information in support of compliance. This included meeting minutes evidencing the engagement of consumers and the service’s newsletter welcoming feedback from consumers and their families.

The evidence provided by the Assessment Team in this requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 8(3)(a) compliant.

Regarding Requirement 8(3)(b), the Site Audit Report states that there was no evidence that the organisations governing body uses information from consolidated reports to identify the service’s compliance with the Quality Standards; initiate improvement actions to enhance performance; or to monitor care and service delivery.

The provider’s response disagreed with this recommendation and provided clarifying information in support of compliance. This included evidence of monthly clinical indicators. The response outlines how spikes in clinical indictors results in a full data analysis and action plan with strategies to manage various areas of clinical care.

The evidence provided by the Assessment Team in this requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 8(3)(b) compliant.

Regarding Requirement 8(3)(c), the Site Audit Report identified the following deficiencies:

* Ineffective information management as staff were not able to demonstrate how they accessed policies and procedures.
* Ineffective continuous improvement systems as the service does not document or monitor continuous improvements.
* Ineffective regulatory compliance systems as 3 consumers who are subject to restrictive practices did not have consent or authorisations in place and 5 consumers who are subject to restrictive practices did not have behaviour support plans in place. Additionally, the Assessment Team identified 5 incidents of unreasonable use of force that were not reported through SIRS.

The provider’s response provided clarifying information:

* The response evidenced that the services management system is accessible to all staff on the computers in the nurse’s stations via a generic login and password. The system provides staff with access to the service’s intranet which includes access to policies which staff can access at any time.
* The response states that the service does have a continuous improvement log that does record and monitor continuous improvements. The response also evidenced the service’s audit program which provides opportunity to identify continuous improvements.
* In relation to lack of consent for the use of restrictive practices for 3 consumers, the response evidenced that verbal consent was obtained for one of the consumers. However, for the second consumer, the response did not provide evidence of consent from the consumer’s representative and for the third consumer the response provided evidence of consent obtained for medication administration however does not specify what the medication is administered for, and what use or diagnosis.
* In relation to 5 consumers not having behaviour support plans in place, the response evidenced that one named consumer had a behaviour support plan in place, however the response did not address whether behaviour support plans are in place for all other consumers subject to restrictive practice.
* In relation to the 5 incidents of unreasonable use of force that were not reported through SIRS, the response stated that the service reviewed all incidents and was not able to identify any incidents that should be reported through SIRS that have not already been reported.

Overall, I am satisfied that the service has effective systems in place in relation to information management and continuous improvement. In relation to regulatory compliance, while I acknowledge the organisation has a system in place for monitoring legislative changes, the service did not demonstrate compliance with restrictive practice legislative requirements to ensure that there is informed consent from consumers or their substitute decision maker for the restrictive practice or behaviour support plans are in place for all consumers subject to restrictive practice. Therefore, based on the evidence before me, I find Requirement 8(3)(c) is non-compliant.

Regarding Requirement 8(3)(d), the Site Audit Report identified several deficiencies. I consider the following relevant to Requirement 8(3)(d):

* The service did not conduct a risk assessment before deactivating the keypad to the lifts allowing consumers access to the basement area and ability to leave the service.
* There was no evidence that the service conducted a risk assessment of 2 named consumers choosing to smoke or the risk associated with them using the fire stairs to access the designated smoking area within the service.
* Management of the service said that they have processes to identify and respond to abuse and neglect of consumers, however they did not provide any supporting documentation.
* The service’s clinical incident records:
  + Did not evidence that aspects of incident management such as investigation of contributing factors, review of existing measures for effectiveness, or development of further preventative measures are considered in the management of incidents.
  + Did not include all incidents reported through SIRS.

The provider’s response provided clarifying information:

* The response clarifies that access to the basement level still requires a keycode and therefore no risk assessment of the potential for consumers to access the basement was required as this was not possible.
* For the named consumers who wish to partake in smoking and access the designated smoking area within the service via the fire stairs, the response clarifies that for one consumer they are unable to walk downstairs and therefore uses the lift and for the other consumer the risk had been assessed.
* The response included the service’s SIRS policy as supporting documentation of the processes to identify and respond to abuse and neglect of consumers.
* The response stated that management and staff do review all incidents, conduct a root cause analysis, discuss mitigation strategies and assess those strategies.

While I acknowledge the response states that incidents are reviewed, evaluated, and monitored, no evidence to demonstrate this occurs was provided. The response did not address why all incidents reported through SIRS were not included in the service’s clinical incident records. For 2 named consumers, high impact and high prevalent risks associated with their care were not effectively managed as discussed under Requirement 3(3)(b).

I find the evidence presented in the Site Audit report is sufficient to demonstrate failure of the service’s management and prevention of incidents. Therefore, based on the evidence before me, I find Requirement 8(3)(d) non-compliant.

I am satisfied the remaining 1 Requirement in Quality Standard 8 is compliant.

Though the Site Audit report identifies deficiencies under Requirement 8(3)(e), those deficiencies have been addressed under other requirements where they are relevant. The service’s clinical governance is provided by an external consultant and had policies and procedures in relation to antimicrobial stewardship, restrictive practices, and open disclosure. Staff were aware of their responsibilities in relation to antimicrobial stewardship and management demonstrated the use of open disclosure.

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