

**Performance Report**

**1800 951 822**

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| Name: | Melbourne Hebrew Memorial Nursing Home |
| Commission ID: | 3836 |
| Address: | 4-8 Freeman Street, CAULFIELD, Victoria, 3162 |
| Activity type: | Site Audit |
| Activity date: | 13 November 2024 to 15 November 2024 |
| Performance report date: | 12 December 2024 |
| Service included in this assessment: | Provider: 1384 Jewish Care (Victoria) Inc  Service: 6903 Melbourne Hebrew Memorial Nursing Home |

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 Melbourne Hebrew Memorial Nursing Home (**the service**) has been prepared by Nicola Eastwood, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others.
* the provider’s response to the assessment team’s report received 6 December 2024.

# 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 | **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 | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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. Consumers confirmed their identity, and culture was valued and understood by staff. Staff demonstrated knowledge of individual consumer choice and dignity. They described consumers with respect while demonstrating knowledge of individual backgrounds. Care documentation reflected individual consumers identity and cultures. Care planning documentation consistently showed consumer cultural needs and preferences documented on the services electronic management system. The Assessment Team report included examples of how the service supports religious preferences, access to a Rabbi and kosher meals.

Consumers confirmed they were able to choose who was involved in their care and when information was communicated. Staff provided examples of how they support consumers to maintain connections and relationships of choice. Staff described how they support consumers to minimise risk and discuss problem solving with consumers and representatives to ensure consumers are living their best lives. Management demonstrated knowledge of processes to support consumer independence. Care files included dignity of risk documentation where appropriate and strategies to support consumer choice contrary to clinical advice.

Information is communicated through email to representatives and consumers are encouraged to attend resident and representative and food focus meetings. Information about menus and events are displayed in common areas and staff described assisting consumers with information in languages other than English.

The service’s privacy policy outlines the collection and storage of consumer personal information. Staff described how they respect consumer choice and privacy when delivering personal care and documentation reflected information is shared within the service and to external organisations as confirmed by consumers.

The Approved Provider submitted additional clarifying information related to Requirement 1(3)(d) and the Assessment Teams observations during the Site Audit. This information reflects the services ongoing commitment to ensuring consumers receive best practice care.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 1.

# 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 were satisfied with the assessment and care planning process. Risk assessments and management processes consider and mitigate identified risks through individual interventions. Management explained that end of life planning is raised during the admission process and the service respects the choice of consumers and representatives to not discuss this in depth. The service’s Rabbi is consulted and assists with treatment choices.

Care planning documentation reflected, the service integrates assessment and care planning involving other organisations, individuals and service providers when developing consumer care plans. There was evidence of inclusion of others in consumer care particularly where complex care needs were identified and appropriate documentation to support treatment needs and referrals.

Outcomes of assessment and planning are communicated to the consumer and their representatives. Staff explained how they regularly communicate with consumers and representatives regarding the outcome of care planning evaluation and changes. Consumer care needs are reviewed every 3 months and when there is a change in condition or after an incident. Staff identified the types of review undertaken depending on incidents and changes of circumstance. Care file documentation reflected 3 monthly reviews as well as timely and responsive review of care and services following incidents and deterioration.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 2.

# 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. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Consumers and representatives expressed satisfaction with the personal and clinical care. Management and staff described best practice in how they deliver care that is safe and tailored to meet individual needs. Restrictive practice is managed in collaboration with the medical practitioner, geriatrician, representative and clinical staff. Consumers receiving psychotropic medication as a form of chemical restraint have informed consent with detailed information related to the use of antipsychotic medications. Individualised behaviour support plans are in place for all consumers with psychotropic medications.

There was evidence of effective wound management with input from medical practitioners and wound consultants where appropriate. Pain assessments and management are reflected in consultation with consumers and representatives. Care documentation reflected pain monitoring, management, and evaluation. The use of alternatives to analgesics for pain management was also documented. The service effectively managed high-impact and high-prevalence risks such as changed behaviours, diabetes management, falls, and complex clinical care requirements. Clinical policies and procedures are available to guide staff practice in areas including care and management of falls, pressure injury, nutrition and hydration and diabetes.

Consumer needs and preferences nearing end-of-life are recognised and addressed, their comfort maximised, and their dignity preserved. Staff described how consumers are kept comfortable at the end-of-life and their dignity maintained including consideration of pain management, mouth care and other comfort measures. Management explained that people of Jewish faith believe the time of death is the choice of God and generally, do not like to speak of or prepare for death, the service assists family with this phase of life by involving the Rabbi and following consumer and representative wishes.

Staff described their knowledge of indicators of deterioration and service policies that guide them in the early identification, assessment and management of consumers, to take appropriate action. There was evidence of identification and escalation of care needs where required. Care file documentation included reference to contributing practitioner recommendations and treatment instructions, behaviour support plans and behaviour evaluation contained comprehensive information about the triggers. The Assessment Team report reflected wound consultant, physiotherapy, residential in-reach and medical practitioners are consulted and involved in consumer care as required.

Staff explained their understanding of how to prevent, recognise, and minimise the spread of infection as well as processes to promote antimicrobial stewardship. The service has an Infection Prevention & Control (IPC) lead staff member and an outbreak management plan for respiratory and gastrointestinal infections. Staff consult with medical practitioners to facilitate collection of pathology specimens for consumers with wounds, or respiratory and gastrointestinal infections prior to commencing antibiotics.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 3.

# 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 the services they received for daily living supported their needs, goals and preferences. Care planning documentation reflected consumer goals, strategies and interventions which were individualised and reflected individual consumer preferences. Staff described how they tailor lifestyle activities through a combination of consumer interests, surveys and discussion with consumers at resident and representative meetings.

Staff demonstrated knowledge of supporting consumers cultural and spiritual well-being by accessing consumer care plans. Management confirmed they regularly seek feedback from consumers through verbal, written and attendance logs to ensure lifestyle activities are meet expectations. The Assessment Team report included examples of consumers engaging religious activities and preparations for Shabbat with a Rabbi.

Consumers confirmed they are able to stay connected with people of importance to them such as family, friends and religious groups. Staff indicated they support consumers to participate in activities they enjoy and are of interest. Care plans detailed activities of interest to consumers and how the service supports them to undertake these interests. Staff and management demonstrated knowledge of consumer needs and supports for daily living and how to refer to organisations to support consumers emotional and social well-being. Documentation showed timely referrals to external organisations and engagement with services such as Men’s Group, Dementia Support Australia (DSA) and The Jewish Council to support consumers emotional and social well-being.

Staff demonstrated knowledge of individual consumer needs and preferences and how to access updated information. Changes to consumer nutrition and hydration preferences are documented and communicated to kitchen staff via the electronic system. Staff explained how they adhere to Kosher catering standards according to Jewish religious observations and menus are reviewed and changed seasonally with the oversight of a dietitian. Consumer dietary preferences and choices recorded, including consumer allergies, likes and dislikes, dietary requirements and preferences were stored in the kitchen and in each kitchenette to ensure each consumers received the correct meal.

Management responded to concerns raised about the temperature of food when served, indicating they are trailing a new order of serving to allow simultaneous service of meals to all consumers.

Staff confirmed they have access to different types of equipment required to provide consumer care and documentation reflected monitoring of equipment condition and safety through the service’s electronic maintenance system.

The Approved Provider submitted additional clarifying information related to Requirement 4(3)(f) and the Assessment Teams observations during the Site Audit. This information reflects the services ongoing commitment to ensuring consumer feedback is considered and contributes to improving the quality of food service.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 4.

# 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

Consumers indicated they find the service environment welcoming and easy to understand. The environment was uncluttered and well-lit, with signage to assist with wayfinding.

There is fr4ee access to indoor and outdoor areas and consumers can move freely around the service. Consumers were satisfied with the cleanliness of the service and indicated it is well maintained. Preventative and reactive maintenance is conducted. The service monitors outstanding maintenance requests to ensure timely action.

Consumers were satisfied furniture, fittings and equipment at the service are clean and well maintained. Staff report faulty equipment and clean shared equipment after use. Allied health professionals ensure the suitability of equipment and there are preventative maintenance schedules in place.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 5.

# 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 indicated they feel supported to provide feedback or make complaints. Feedback can be provided using feedback forms, at consumer and relative meetings, surveys or conversations with management.

Consumers were aware of alternate methods for making complaints including through the Aged Care Quality and Safety Commission. Advocacy information was available at the service and within the consumer handbook, and staff outlined a presentation to consumers by the Older Persons Advocacy Network (OPAN) during the month preceding the Site Audit. Staff have access to interpreter cards to aid communication with consumers of non-English speaking backgrounds.

Most consumers and representatives were satisfied with how complaints are managed. Management was described as receptive and responsive and as providing an explanation for issues of concern. Consumer feedback indicated issues raised are addressed and resolved where possible. In response to feedback that staff do not always express regret or provide an apology when consumers are dissatisfied, management provided staff training in open disclosure.

There was evidence the service uses feedback and complaints to improve care and services. As a result of complaints trends the service has made recent adjustments to the dining experience to ensure all consumers are served their meals at the same time.

The Approved Provider submitted additional clarifying information related to Requirement’s 6(3)(c) and 6(3)(d) the Assessment Teams observations during the Site Audit. This information reflects the services ongoing commitment to ensuring consumer feedback is considered and contributes to improving the provision quality care and services.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 6.

# 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 that Requirement 7(3)(e) was non-compliant, however with consideration to the available information and Approved Provider response, I am satisfied that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Requirement 7(3)(e)

The service did not demonstrate regular assessment, monitoring and review of staff performance occurs. Evidence was provided of reactive management of performance deficits, but evidence was not provided to demonstrate planned assessment or review. Eight staff members indicated they had not completed a performance appraisal within the year preceding the Site Audit, and 6 indicated they had not undergone a probation appraisal. Management provided 3 completed staff performance appraisals, completed in 2021, 2023 and 2024. In response to feedback management indicated that due to recent staffing changes appraisals had not been completed and provided a plan for performance appraisals for a small number of staff, to be completed following the Site Audit in November 2024. No plan was provided for completion of performance appraisals for remaining staff.

The Approved Provider submitted a response, additional evidence of completed actions as well as a supporting Plan for Continuous Improvement (PCI). The service has provided training and open communication to staff regarding performance monitoring and review and has now completed the majority of outstanding performance appraisals. The response included evidence of completion, provision of policies, FAQ sheets and guidelines as well as meeting minutes supporting discussions with staff.

I am reassured by the Approved Provider response that the service is aware of its obligations to monitor and review staff performance. The supporting evidence submitted with the response also demonstrates action was swiftly taken following the Site Audit and a plan to ensure ongoing compliance with this Requirement. As a result, I consider Requirement 7(3)(e) now compliant.

Compliance with remaining Requirements

Most consumers and representatives were satisfied with staffing at the service and staff capacity to respond to call bells. Staff confirmed staffing levels are sufficient to enable them to perform their duties. Agency staff are used to fill shifts when casual or permanent staff of the service are not available. A registered nurse is available 24 hours a day, and the roster is planned to ensure sufficient staffing even in the event of unplanned leave. Call bell data demonstrated response times are mostly under the service’s benchmark of 11 minutes.

Consumers and representatives confirmed staff are kind and respectful, one stating staff treat the consumer ‘like royalty’. Staff attend an ‘ethos day’ to introduce them to Judaism. While some representatives felt agency staff do not know the consumers well, they were satisfied the service is doing everything possible to recruit staff. In response to feedback management confirmed recruitment is ongoing.

The Assessment Team report reflected staff are competent to perform their roles. Staff are knowledgeable in relation to the care and services required by consumers, and qualifications, registrations and skills are monitored.

Consumers and representatives were satisfied staff are suitably trained. Staff are required to complete mandatory training completion is monitored. Mandatory training includes training in the Serious Incident Response Scheme (SIRS). Dementia care training is also offered. Training is provided during orientation for agency staff.

# 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. | Compliant |

**Findings**

The Assessment Team recommended that Requirement 8(3)(c) workforce governance was non-compliant, however with consideration to the available information and Approved Provider response, I am satisfied that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Requirement 8(3)(c)

The service did not demonstrate an effective governance system in relation to workforce governance. While qualifications, professional registrations, and compliance with mandatory training are monitored, the service was not regularly monitoring and reviewing staff performance. The service provided evidence of response to performance deficits, however at the time of the Site Audit planned staff performance appraisals had not occurred within the preceding 2 years for most staff.

In response to the identified deficits with sub requirement 8(3)(c)(iv) the Approved Provider will implement audit system to support governance of staff performance and ensure monitoring and compliance with the performance development system is maintained. I am reassured that the service has completed the majority of outstanding performance appraisals and is aware of its obligations to ensure ongoing reporting and governance of compliance with staff performance oversight. I consider the actions implemented will address the identified deficit and consider this Requirement compliant.

The service demonstrated effective governance systems in relation to information management, continuous improvement, finances, regulatory compliance, and feedback and complaints. Staff have access to accurate and sufficient information to perform their roles. The service maintains a PCI and opportunities for improvement are identified through consumer and representative feedback, audits, and incidents. The service has systems and processes in place to manage the finances and resources required to deliver safe and quality care. Management develops business cases for new initiatives which are submitted for approval by those authorised.

The organisation has a legal advisory service which assists to ensure regulatory compliance. Policies and procedures ensure legislative changes are monitored and relevant policies updated. There are systems and processes in place to encourage and support consumers to provide feedback which is then reported to the governing body for oversight.

Compliance with remaining Requirements

Consumers and representatives confirmed they can have input into service improvements. The organisation has a consumer advisory committee with representatives from all services, and regular food focus and resident and relative meetings are conducted onsite. Consumer feedback has led to changes in process to ensure consumers who require modified diets receive their meals at the same time as other consumers.

The service has a suite of policies, procedures and work instructions which support and guide management and staff to provide a safe and inclusive environment. Key performance indicators and critical incidents are escalated to the executive and governing body, to enable the oversight of care and service delivery. This information is provided through a hierarchy of committees, sub-committees, and established reporting lines. Daily senior leadership and clinical governance meetings occur to monitor and review the service’s performance against the Aged Care Quality Standards. A recently introduced safety measure was outlined involving the introduction of a security guard at the entrance to the service to ensure consumer safety in the context of the war in the Middle East.

The organisation has comprehensive risk and incident management systems which support the identification and management of abuse and neglect, and more broadly the management and prevention of incidents. Staff complete mandatory training in relation to harm, abuse and neglect, and know how to report such incidents. The service has identified changed behaviours as a high prevalence risk and in response has introduced a dementia education program for staff, to facilitate the early recognition of such behaviours.

The service has a comprehensive clinical governance framework to ensure consumers receive safe and quality care and services. Core elements of governance are outlined within the framework including monitoring and reporting, leadership and culture, and partnering with consumers. The framework is supported by policies, processes, auditing and reporting. There is a hierarchy of committees and working groups to ensure systems and processes are maintained to reflect contemporary practice. The use of restrictive practices is reported to the Board. The organisation has provided staff with education and training in regard to antimicrobial stewardship and staff were able to outline how these principles are applied in practice. The organisation has a work instruction relating to open disclosure, and in response to Assessment Team feedback management indicated they would update the service’s PCI with an action to monitor staff documentation of apologies in line with the work instruction.

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